MILLIMAN CLIENT REPORT

Calendar Year 2019 Healthy Connections Prime Capitation Rate Certification – Medicaid Rate Component

FINAL

January 1, 2019 through December 31, 2019

South Carolina Department of Health and Human Services

September 10, 2019

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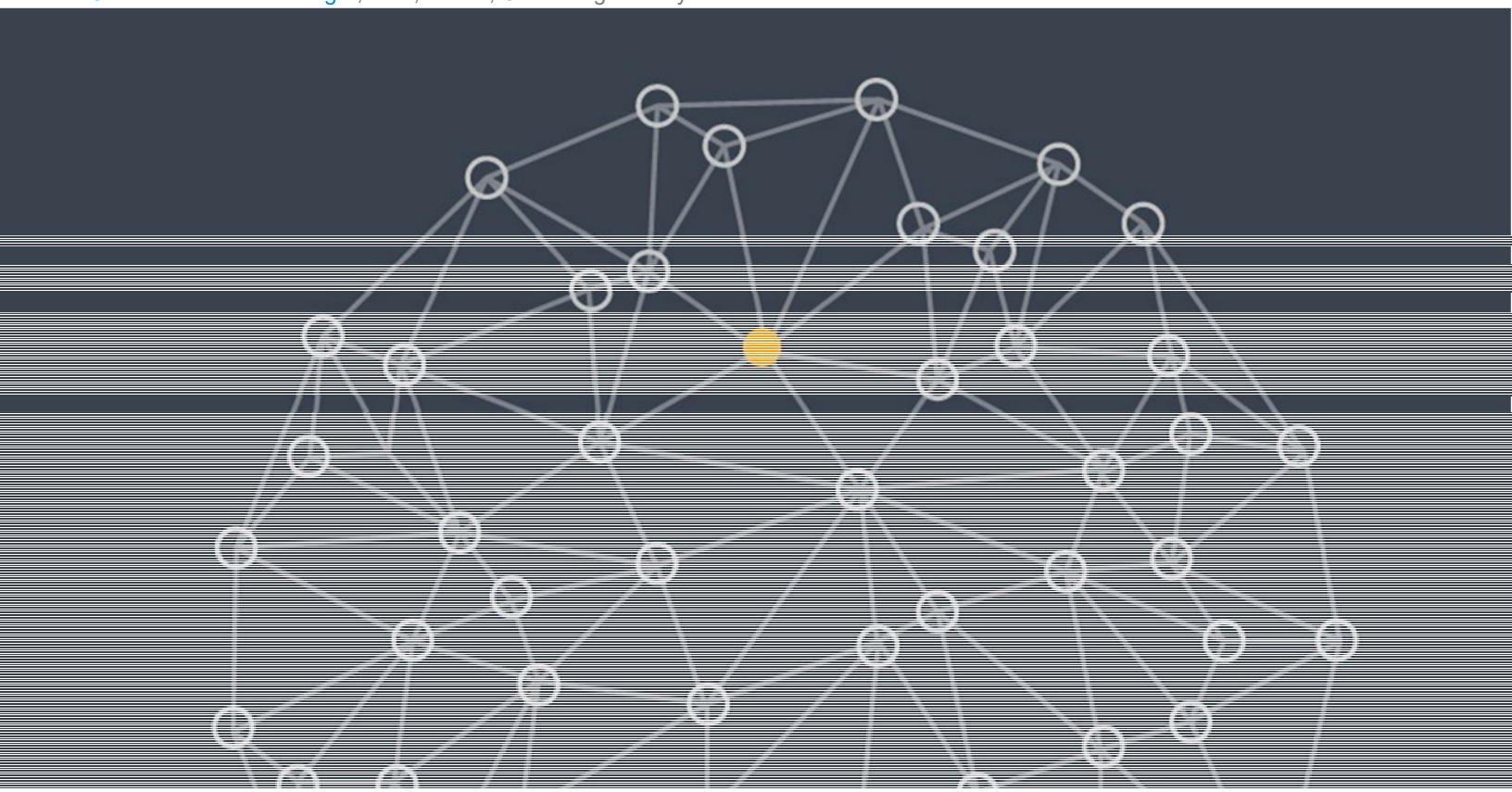

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Table of Contents

Introduction & Executive Summary

BACKGROUND

Milliman, Inc. (Milliman) has been retained by the State of South Carolina Department of Health and Human Services (SCDHHS) to provide actuarial and consulting services related to the development of actuarially sound capitation rates for the Healthy Connections Prime Program (Prime) effective January 1, 2019. These rates will be in effect through December 31, 2019. Prime is South Carolina's managed care program for the dual eligible (Medicare-Medicaid) population.

This letter provides the documentation for the development of the actuarially sound capitation rates for CY 2019. It also includes the required actuarial certification in Appendix A. Unless otherwise specified, all references to "rates" or "capitation rates" throughout this document refer to the Medicaid-specific component of the Healthy Connections Prime program capitation rates.

To facilitate review, this document has been organized in the same manner as the 2018-2019 Medicaid Managed Care Rate Development Guide, released by the Center for Medicare and Medicaid Services in April 2018 (CMS guide). Section III of the CMS guide is not applicable to this certification as the covered services do not include rates for new adult groups under 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

FISCAL IMPACT ESTIMATE

The certified per member per month (PMPM) capitation rates for the Healthy Connections Prime program are illustrated in Figure 1. These rates are effective from January 1, 2019 through December 31, 2019. Figure 1 provides a comparison of the calendar year (CY) 2019 rates relative to the rates effective July 1, 2018 through December 31, 2018 (July 2018 rates). The rates in Figure 1 reflect a 3% shared savings percentage for CY 2019.

FIGURE 1: Comparison with July 2018 through December 2018 Rates by Rate Cell (PMPM Rates)

Rate Cell	CY 2019 Projected Membership	Jul 2018 - Dec 2018 Medicaid Rate	CY 2019 Medicaid Rate	Increase/ (Decrease)
Community	155,988	$ 86.00	$86.44	0.5%
Nursing Facility	1,740	5,488.45	5,617.24	2.3%
HCBS Waiver	28,740	1,237.72	1,335.74	7.9%
HCBS Waiver – Plus	900	3,480.32	3,598.85	3.4%
Composite	**187,368**	**$ 329.13**	**$ 346.30**	**5.2%**

Please note:

- The capitation rates reflect the current benefit package for CY 2019 approved by the State and CMS as of the date of this report. The rates will be revised appropriately if applicable policy and program changes occur for this period.
- The Nursing Facility capitation rate was developed based on projected gross nursing facility rates. On an individual basis, SCDHHS will deduct the actual patient pay liability amount from the 2019 Nursing Facility capitation rate shown in Figure 1 and pay the net capitation rate to the coordinated and integrated care organizations (CICOs).
- The HCBS Waiver – Plus rate was calculated as the HCBS Waiver base rate plus two-thirds of the difference between the institutional portion of the Nursing Facility rate (less an estimated average daily patient liability amount of $33.39) and the waiver services portion of the HCBS Waiver base rate.

The estimated fiscal impact of the CY 2019 Prime capitation rates compared to the July 2018 Prime capitation rates, on a state and federal expenditures basis is a $3.2 million increase based on the projected enrollment for CY 2019.

The estimated stratification of total expenditures under both July 2018 and CY 2019 Prime rate scenarios is illustrated on a rate cell basis in Figure 2. State and federal allocations are illustrated using the Federal Fiscal Year 2019 FMAP of 71.22%.

FIGURE 2: Estimated Fiscal Impact (Millions)

		Projected Annual Expenditures		Dollar	Percentage
Rate Cell	CY 2019 Projected Membership	Jul-18	CY 2019	Increase/ (Decrease)	Increase/ (Decrease)
Community	155,988	$ 13.4	$ 13.5	$ 0.1	0.5%
Nursing Facility	1,740	$ 9.5	$ 9.8	0.2	2.3%
HCBS Waiver	28,740	$ 35.6	$ 38.4	2.8	7.9%
HCBS Waiver – Plus	900	$ 3.1	$ 3.2	0.1	3.4%
Composite	**187,368**	**$ 61.7**	**$ 64.9**	**$ 3.2**	**5.2%**
Total State and Federal		$ 61.7	$ 64.9	$ 3.2	5.2%
Total Federal Only		$ 43.9	$ 46.2	2.3	5.2%
Total State		$ 17.7	$ 18.7	0.9	5.2%

Notes:

1. July 2018 and CY 2019 aggregate annual expenditures were developed based on CY 2019 projected enrollment.
2. State expenditures based on Federal Fiscal Year 2019 FMAP of 71.22%.
3. CY 2019 projected enrollment was developed using capitation payment data through September 2018, information from SCDHHS regarding monthly passive enrollment expectations in CY 2019, and opt-out assumptions for passively enrolled members.
4. Values are rounded.

Section I. Medicaid managed care rates

1. General information

This section provides information listed under the General Information section of CMS guide, Section I.

The capitation rates provided under this certification are "actuarially sound" for purposes of 42 CFR 438.4(a), according to the following criteria:

- The capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the managed care plan for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).

Assessment of actuarial soundness, in the context of Prime, should consider both Medicare and Medicaid contributions and the opportunities for efficiencies unique to an integrated care program. CMS considers the Medicaid actuarial soundness requirements to be flexible enough to consider efficiencies and savings that may be associated with Medicare. Therefore, CMS does not believe that a waiver of Medicaid actuarial soundness principles is necessary in the context of this Demonstration.

To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification).
- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective for the SFY 2019 managed care program rating period.
- The *2018-2019 Medicaid Managed Care Rate Development Guide* published in April 2018 by CMS.
- The "Joint Rate-Setting Process for the Financial Alignment's Capitated Model" published by CMS on April 25, 2017[1].
- Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term "actuarially sound" will be defined as in ASOP 49:

"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes."[2]

In the development of the capitation rates for the Prime program, we relied on regulatory guidance related to the capitation rate setting methodology and the mandatory joint savings percentage required by the three-way contract.

[1] "Joint Rate-Setting Process for the Financial Alignment's Capitated Model", https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/JointRateSettingProcess042517.pdf. Accessed 5/4/2018.

[2] http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/

A. RATE DEVELOPMENT STANDARDS

i. Annual basis

The actuarial certification contained in this report is effective for the capitation rates for the one year rate period from January 1, 2019 through December 31, 2019.

ii. Required elements

(a) Actuarial certification

The actuarial certification, signed by Marlene T. Howard, FSA, is in Appendix A. Ms. Howard meets the qualification standards established by the American Academy of Actuaries, follows the practice standards established by the Actuarial Standards Board, and certifies that the final rates meet the standards in 42 CFR 438.4(a).

(b) Certified capitation rates for each rate cell

The certified capitation rates by rate cell are illustrated in Appendix B. These rates represent the Medicaid component of the contracted capitation rates to the CICOs. For the Nursing Facility rate cell, the rates are developed on a gross basis, prior to the application of patient liability. On an individual basis, SCDHHS will deduct the actual patient pay liability amount from the Nursing Facility capitation rate shown in Figure 1 and pay the net capitation rate to the CICO.

(c) Program information

(i) Managed Care program

SCDHHS, along with CMS and the Prime CICOs, provides benefits for full benefit dual eligibles under the Healthy Connections Prime program in all counties with at least one operating CICO. This letter provides the documentation and certification of the CY 2019 capitation rates for the Medicaid component of the Prime program.

Healthy Connections Prime began enrollment in February 2015 with 4 full-risk managed care plans of which 3 remain for the CY 2019 contract year. This certification is for Demonstration Year 4, which coincides with CY 2019. In 2018, CMS granted an extension of the initial three-year dual-demonstration in South Carolina, through CY 2020[3].

The rate cell structure is further described in section (c), item (iii) below. Enrollees must be at least 65 years of age and not residing in a nursing facility at the time of enrollment into the Prime program.

The services provided under the contract cover a comprehensive benefit package, including acute care and long-term services and supports. The program pays secondary to Medicare for Medicare covered services.

(ii) Rating period

This actuarial certification is effective for the one year rating period January 1, 2019 through December 31, 2019.

(iii) Covered populations

Target Population

The target population for the Prime program was limited to full Medicare-Medicaid dual eligible individuals who are age 65 and over and entitled to benefits under Medicare Parts A, B, and D. The Prime program is offered in all counties with at least one operating CICO, representing 39 counties, and includes individuals enrolled in the Community Choices Waiver, HIV/AIDS Waiver and Ventilator Dependent Waiver.

[3] July 1, 2018 changes to the Three-Way Contract: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/SCContractSummaryOfChanges_07012018.pdf

Excluded Populations

The following populations are not eligible for the Prime program and are excluded from enrollment:

- Any member month where an individual's age was under 65;
- Any member month where an individual is enrolled in the PACE program;
- Any member month where an individual is enrolled in a DDSN waiver;
- Any member month where an individual was identified as partial eligible. These individuals consisted of those with the following payment categories in the eligibility data:
    - 90 – Qualified Medicare Beneficiary;
    - 48 – Qualifying Individual;
    - 52 – Specified Low Income Medicare Beneficiary;
    - 14 – MAO (General Hospital);
    - 50 – Qualified Working Disabled;
    - 55 – Family Planning;
    - 70 – Refugee Entrant.
- Any member month where an individual was not enrolled in Medicare Part A and Medicare Part B coverage;
- Any member month where an individual resides in hospice or a nursing facility.

The following criteria were not evaluated due to limitations in the data:

- Medicare Part D enrollment
- Eligibility for ESRD services

Additional detail related to the eligible and excluded populations can be found in the three-way contract between SCDHHS, CMS, and the participating CICOs.

The following describes each of the distinct populations covered by the Prime program which correspond directly with the capitation rate cells.

Home and Community-Based Services (HCBS) Waiver Population

This population includes individuals participating in one of the non-Developmentally Disabled 1915(c) waiver programs operating in South Carolina.

Milliman identified the population in the rate-setting process by assigning to the HCBS Waiver population any member month where an individual contains any of the following codes on the first day of the month in the eligibility data indicating recipient of a special program (RSP):

- **CLTC**: Community Choices Waiver
- **HIVA**: HIV/AIDS Waiver
- **VENT**: Ventilator Dependent Waiver

Nursing Facility Population

This population includes individuals residing in a nursing facility who meet the state definition of nursing home level of care and who are not enrolled in a home and community-based services (HCBS) waiver. This rate cell was established for Demonstration-enrolled individuals who transition from the community to a nursing facility and elect to remain in the Demonstration. In developing the base data used in the capitation rate-setting process, we identified the nursing facility population using the following criteria:

- Any dual-eligible individual with at least one day of service in an institution (DHHS nursing home, Department of Mental Health (DMH) nursing home, nursing home swing beds, hospice room & board, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)) and denoted as meeting the nursing home level of care criteria based on the payment category field in the SCDHHS eligibility data.

- Any Prime-eligible member who has incurred more than three consecutive months of nursing facility services following the month of admission, yet did not contain a nursing facility level of care payment category on the eligibility record.

The capitation rate for this rate cell was developed based on projected gross nursing facility rates. On an individual basis, SCDHHS will deduct the actual patient pay liability amount from the Nursing Facility capitation rate shown in Figure 1 and pay the net capitation rate to the CICOs.

Community Residents Population

This population includes all other qualifying individuals who were not previously categorized. This population is comprised of Demonstration-eligible individuals who are neither institutionalized nor participating in a 1915(c) waiver program.

"Plus" Rates

For Prime program participants who transition between settings of care, additional considerations will be taken when assigning the capitation rate cell payment. Demonstration Plans will receive "Plus" rates for certain individuals to encourage transition from institutional care to the community setting.

Individuals who require HCBS waiver services once moved to the community will receive the Waiver Plus rate. This rate was calculated as the HCBS Waiver base rate plus two-thirds of the difference between the institutional portion of the Nursing Facility rate (less an estimated average patient liability amount) and the waiver services portion of the HCBS Waiver base rate.

The Plus rates will be paid for a three-month period meeting the following conditions:

- Any Prime enrollee discharged from a nursing facility to an HCBS waiver.
- Any Prime enrollee, first eligible for nursing facility services or HCBS waiver services, who is served in a HCBS waiver without being admitted to a nursing facility.

For an individual transitioning to a nursing facility from the community, the health plan will receive the member's base rate from the place of transfer for the first three months in the nursing home. This payment methodology is consistent with the CY 2018 payment methodology.

(iv) Eligibility criteria

Enrollment in Prime is not mandatory for eligible individuals. The capitation rates reflect monthly passive enrollment throughout CY 2019. Passively-enrolled individuals are placed in a CICO, but can opt out of the Prime program at any time. Those individuals who opt-out of the program are placed back in fee-for-service.

(v) Special contract provisions

This rate certification report contains documentation of the following special contract provisions related to payment included within rate development.

- Withhold arrangements
- Minimum medical loss ratio requirement

Please see Section I, item 4, Special Contract Provisions Related to Payment, for additional detail and documentation.

(vi) Retroactive adjustment to capitation rates

This rate certification report does not include a retroactive adjustment to the CY 2018 capitation rates.

iii. Differences among capitation rates

Any proposed differences among capitation rates according to covered populations are based on valid rate development standards and are not based on the rate of federal financial participation associated with the covered populations.

iv. Cross-subsidization of rate cell payment

The capitation rates were developed at the rate cell level and neither cross-subsidize nor are cross-subsidized by payments from any other rate cell.

v. Effective dates

To the best of our knowledge, the effective dates of changes to the SC Healthy Connections Prime program are consistent with the assumptions used in the development of the certified CY 2019 capitation rates.

vi. Generally accepted actuarial practices and principles

(a) Reasonable, appropriate, and attainable

In our judgment, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs, and have been included in the certification.

(b) Outside the rate setting process

There are no adjustments to the rates performed outside the rate setting process.

(c) Final contracted rates

The CY 2019 capitation rates certified in this report represent the final contracted rates by rate cell.

vii. Rate certification for effective time periods

This actuarial certification is effective for the one year rating period January 1, 2019 through December 31, 2019.

viii. Procedures for rate certification and amendment

In general, a new rate certification will be submitted when the rates change. The following exceptions are allowed per §438.7 of CMS 2390-F:

1. A contract amendment that does not affect the rates.
2. An increase or decrease of up to 1.5% in the capitation rate per rate cell.

In cases 1 and 2 listed above, a contract amendment must still be submitted to CMS.

B. APPROPRIATE DOCUMENTATION

i. Documentation of required elements

This report contains appropriate documentation of all elements described in the rate certification, including data used, assumptions made, and methods for analyzing data and developing assumptions and adjustments.

ii. Index

The index to this rate certification is the table of contents, found immediately after the title page. The index includes section numbers and related page numbers. Sections not relevant to this certification continue to be provided, with an explanation of why they are not applicable.

iii. Different FMAP

All populations receive the regular state FMAP of 71.22% for FFY 2019 and 70.70% for FFY 2020.

iv. Comparison to final certified rates in the previous rate certification.

The previous rate certification applied to July 2018 through December 2018 capitation rates. A comparison to July 2018 through December 2018 certified rates by rate cell is provided in Figure 1.

2. Data

This section provides information on the data used to develop the capitation rates. The experience data described in this section is illustrated in Appendices C through E.

A. RATE DEVELOPMENT STANDARDS

In accordance with 42 CFR §438.5(c), we have followed the rate development standards related to base data. The remainder of Section I, item 2 provides documentation of the data types, sources, validation process, material adjustments and other information relevant to the documentation standards required by CMS.

B. APPROPRIATE DOCUMENTATION

i. Requested data

As the actuary contracted by SCDHHS to provide consulting services and associated financial analyses for many aspects of the South Carolina Healthy Connections program (and not just limited to capitation rate development), Milliman intakes and summarizes eligibility and expenditure data on a monthly basis from Clemson, SCDHHS's data administrator. As such, there is no separate data request from Milliman to the state specifically related to the base data for the capitation rate development. The remainder of this section details the base data and validation processes utilized in the CY 2019 capitation rate development. Additionally, Appendices C1, D1, and E1 summarize the unadjusted base data for each rate cell.

ii. Data used to develop the capitation rates

(a) Description of the data

(i) Types of data

The primary data sources used or referenced in the development of the capitation rates are the following:

- Fee-for-service (FFS) claims data for the Prime eligible population incurred January 1, 2015 through December 31, 2017 and paid through September 2018;
- Detailed FFS enrollment data for January 1, 2015 through December 31, 2017
- Managed care capitation rates paid to the health plans serving enrollees in the Prime program
- Summary of policy and program changes through CY 2019 (including changes to fee schedules and other payment rates)
- Enrollees in a Dual Eligible Special Needs Plan (D-SNP) during the base period
- Monthly passive enrollment estimates and member files for January 2019
- Healthy Connections Prime enrollment data by rate cell for September 2018
- Data exchange files between SCDHHS and CMS implemented by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) for July 2016 through June 2018
- CY 2017 quarterly Form CMS-64 reports detailing costs associated with Medicaid program expenditures and administrative expenses.

(ii) Age of the data

The data serving as the base experience in the capitation rate development process was developed using CY 2017 historical incurred FFS claims and enrollment experience limited to the targeted population. The FFS data used in our rate development process reflects data adjudicated through September 2018.

For the purposes of trend development and analyzing historical experience, we also reviewed FFS claims and enrollment experience from January 2015 through December 2017. We utilized enrollment through September 2018 for projecting CY 2019 enrollment.

(iii) Data sources

The historical claims and enrollment experience data was provided by SCDHHS.

The following data sources were also used in the development of the CY 2019 Prime capitation rates:

- 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (2018 Annual Trustees Report) (Source link: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf)
- Three-way contract between CMS, SCDHHS, and the Health Plan (Source link: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/SouthCarolinaContract.pdf)
- South Carolina Contract Amendment (7/1/2018) (Source link: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/SCContractAmendment_07012018.pdf)
- Memorandum of Understanding (MOU) between CMS, and the State of South Carolina (Source link: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/SCMOU.pdf)

(iv) Sub-capitation

The FFS data does not contain sub-capitated amounts.

(b) Availability and quality of the data

(i) Steps taken to validate the data

The FFS data is provided by SCDHHS. Milliman has many years of experience working with SCDHHS's FFS data. We perform routine reconciliation of SCDHHS's financial data as part of the monthly data validation process and provide budgeting and forecasting assistance to the State, which involves aggregate claim reconciliation to SCDHHS's financial statements.

Completeness

Milliman and SCDHHS both play a role in validating FFS data for completeness. Milliman summarized the data to look for anomalies in the base data year. The data is segmented by rate cell and service category.

The annual rate setting process for CY 2019 uses one year of FFS experience data, with nine months of run-out. The nine months of claims run-out after the end of the base period results in incurred but not reported (IBNR) claim liability estimates having a limited effect on the estimated incurred expenditures for CY 2017. However, as noted in section I.2.B.ii, claims completion is applied to the FFS data for estimated CY 2017 claims adjudicated after September 30, 2018.

Accuracy

The data is subjected to a series of validation checks. For example, all claims must contain a valid Medicaid recipient ID for an individual who was enrolled at the time the service was provided. The data is also checked to ensure the service is a covered benefit under the Prime program. Additionally, all claims must contain a valid provider ID and other codes necessary to provide payment, such as procedure codes, revenue codes, or DRG codes.

(ii) Actuary's assessment

As required by Actuarial Standard of Practice (ASOP) No. 23, Data Quality, we disclose that Milliman has relied upon certain data and information provided by SCDHHS. The values presented in this letter are dependent upon this reliance.

The FFS data represents the most appropriate data to be used for developing the actuarially sound capitation rates for the CY 2019 Prime program, subject to our reliance on regulatory guidance to estimate baseline costs absent the Demonstration for the dual demonstration capitation rate setting process.

(iii) Data concerns

We have not identified any material concerns with the quality or availability of the data.

(c) Appropriate data

(i) Use of encounter and fee-for-service data

We confirm that FFS claims and enrollment were used as the primary data source for this certification. The base data reflects the historical experience and covered services most closely aligned with the Prime program. As noted below, encounter data was not utilized for the Prime capitation rate development.

(ii) Use of managed care encounter data

Encounter data was not used for this certification. In absence of the Demonstration, the dual eligible population is served by the FFS delivery system.

(d) Reliance on a data book

Development of the capitation rates did not rely on a data book or other summarized data source. We were provided with detailed FFS claims data and enrollment for all covered services and populations.

iii. Data adjustments

Capitation rates were developed from historical CY 2017 FFS data, paid through September 2018. As shown in Appendices C through E and further described in this report, adjustments include completion, reimbursement changes, and other program changes.

(a) Credibility adjustment

The Prime eligible populations, as represented in the base experience, were considered fully credible. No adjustments were made for credibility in the base data.

(b) Completion adjustment

Claim payment lag analyses were performed separately for the major categories of service that were incurred by the Community, Nursing Facility and HCBS Waiver populations.

The adjustment factors presented in Figure 3 were developed from a combination of claim payment lag analyses and estimates of projected PMPMs, which were applied to CY 2017 expenditures to reflect completion of IBNR claims. The CY 2017 base period provides for 9 months of claims payment runout from the end of CY 2017.

The claim completion factors applied to CY 2017 are illustrated by population and major service category in Figure 3.

FIGURE 3: Completion Factors Applied to CY 2017 Experience Data

Category of Service	Community	Nursing Facility	HCBS Waiver
Inpatient	1.0102	1.0084	1.0088
Outpatient	1.0322	1.0161	1.0301
Institutional	1.0212	1.0071	1.0219
Physician	1.0121	1.0069	1.0062
Pharmacy	1.0000	1.0003	1.0000
Ancillaries	1.0536	1.0790	1.0191
Waiver Services	1.0000	1.0000	1.0000

(c) Errors found in the data

Our observation of institutional claims data for the Prime-eligible population indicates that the payment category field used to identify nursing facility level of care does not align with nursing facility utilization in all cases.

As such, additional criteria was used to identify members who incurred more than three consecutive months of nursing facility services following the month of admission. Each of these members was assigned to the Nursing Facility rate cell in the development of the base data.

(d) Program change adjustments

The base data represents a historical time period from which projections were developed. We reviewed prior rate setting documentation and other materials from SCDHHS to identify program changes that were implemented during the base data period. To the extent the program adjustments were estimated to have a material impact on CICO service costs, an adjustment was considered for the CY 2019 rate development process. Adjustments were made to the portion of the base data prior to the implementation of each program change in order to ensure the entire base period was on a consistent basis. All program and reimbursement changes that have occurred in the Medicaid managed care program since January 1, 2017, the beginning of the base experience period used in the capitation rates, are described below.

A. Adjustments to the Base Data Period

Changes in provider reimbursement and program changes were evaluated for each category of service. These adjustments are shown in Appendices C1, D1, and E1.

A.1. Nursing Facility Reimbursement Changes

Reimbursement changes implemented for nursing facilities during the CY2017 base period are described in the following section.

The impact of the nursing facility reimbursement changes listed below were evaluated by performing a repricing analysis on the respective individual nursing facility claims impacted by each rate change. The fee schedules used in the repricing analysis were derived based on observed daily rates in the FFS data.

We excluded claims where we were unable to identify the appropriate nursing facility rate as a result of unknown provider IDs. The application of this exclusion criteria was minimal, with approximately 98% of the claims remaining in the repricing analysis for each of the evaluated reimbursement changes

Effective October 1, 2017, SCDHHS implemented a reimbursement rate change to nursing facilities. Using the repricing analysis described above, the resulting impact of this rate change across all rate cells for the DHHS nursing home and hospice room & board categories of service was approximately 2.1%. This increase was applied as a retrospective program adjustment for the period January 2017 through September 2017.

Effective October 1, 2017, SCDHHS implemented a reimbursement rate change to DMH nursing facilities; however, experience data indicates the fee schedule change was not fully implemented until December 1, 2017. Using the repricing analysis described above, the resulting impact of this rate change across all rate cells for the DMH nursing home category of service was approximately 1.9%. This increase was applied as a retrospective program adjustment for the period January 2017 through November 2017.

A.2. Patient Liability Adjustment

The addition of patient liability expenditures for the Hospice Room & Board category of service was included as a historical adjustment. The base experience data does not reflect these payments, nor are the payments readily available in our data sources. Therefore, we estimated the Hospice Room and Board gross daily rate based on the Nursing Home payments. We estimated DHHS and DMH Hospice Room and Board patient liability per day as equal to DHHS and DMH Nursing Home Room and Board patient liability per day, respectively.

The impact of adding estimated patient liability to the hospice room and board net daily rates for CY 2017 is approximately 24.3%. **This adjustment is applied to the Nursing Facility rate cell only** and is included in the program and policy adjustments column in Appendix D1.

A.3. Waiver Services Changes

Effective July 1, 2017, SCDHHS implemented an increase to the monthly case management reimbursement rate from $65 to $72. This increase was applied as a retrospective program adjustment for the period January 2017 through June 2017.

B. Prospective Program Changes

Prospective program and reimbursement changes are shown in Appendices C2, D2, and E2

B.1. Nursing Facility Reimbursement Changes

Effective January 1, 2018, SCDHHS implemented a reimbursement rate change to the Non-Emergency Medical Transportation (NEMT) portion of the DHHS nursing facility rates. Based on a public notice posted by SCDHHS and assumed patient liability, we applied an adjustment to the DHHS nursing home and hospice room & board service categories. The estimated impact on the affected service categories is approximately 0.5% on the Nursing Facility rate cell and 0.7% on the Community and HCBS Waiver rate cells.

Effective January 1, 2018, SCDHHS implemented a reimbursement rate change to DMH nursing facilities. Based on the DMH nursing facility fee schedules provided by SCDHHS, we applied an adjustment to the DMH nursing home service category. The estimated impact on the affected service category is approximately 0.3% on all rate cells.

Effective October 1, 2018, SCDHHS implemented a reimbursement rate change to DHHS nursing facilities. Based on a public notice posted by SCDHHS and assumed patient liability, we applied an adjustment to the DHHS nursing home and hospice room & board service categories. The estimated impact on the affected service categories is estimated at 2.8% on the Nursing Facility rate cell and 2.5% on the Community and HCBS Waiver rate cells.

B.2. Part A Deductible

Effective January 1, 2018, the Medicare Part A deductible increased from $1,288 in CY 2017 to $1,340 in CY 2018. This projection was provided in the June 5, 2018 Annual Trustees Report. The estimated impact resulting from the Medicare Part A deductible change from CY 2017 to CY 2018 is an increase to inpatient expenditures of approximately 1.2% for the Community rate cell, 1.5% for the Nursing Facility rate cell, and 1.3% to the HCBS Waiver rate cell.

Effective January 1, 2019, the Medicare Part A deductible is anticipated to increase from $1,340 in CY 2018 to $1,364 in CY 2019. This projection was provided in the June 5, 2018 Annual Trustees Report. The estimated impact resulting from the Medicare Part A deductible change from CY 2018 to CY 2019 is an increase to inpatient expenditures of approximately 1.1% for the Community rate cell, 1.5% for the Nursing Facility rate cell, and 1.3% to the HCBS Waiver rate cell.

B.3. Waiver Services Reimbursement Changes

Effective July 1, 2018, SCDHHS implemented a reimbursement rate change to Personal Care I, Personal Care II, Adult Day Health Care, and Attendant Care waiver services. Based on the updated July 1, 2018 waiver services fee schedule provided by SCDHHS, the impact on the affected service categories is estimated at 7.9% on the HCBS Waiver rate cell. There is no material impact for the Nursing Facility and Community rate cells.

C. Program changes deemed immaterial to benefit expenses in the rate period

Adjustment factors were developed for policy and program changes estimated to materially affect the dual eligible population that are not fully reflected in the CY 2017 base experience period.

Program adjustments were made in the rate development process to the extent a policy or reimbursement change is deemed to have a material cost impact to the dual eligible population. We defined a program adjustment to be material if the total expense for any individual rate cell is impacted by more than 0.1%. The following is a list of program adjustments deemed immaterial based on our review of experience data and policy change

Effective July 1, 2017, SCDHHS implemented an increase to the private duty nursing (procedure codes T1002 and T1003) fee schedule. The impact was estimated at less than 0.1% for each rate cell and deemed to be immaterial.

Effective July 1, 2017, SCDHHS updated the July 1, 2016 SCDMH clinic rates to reflect the calendar year 2017 Medicare Economic Index trend rate. The impact was estimated at less than 0.1% for each rate cell and deemed to be immaterial.

Effective January 1, 2019, the Medicare Part B deductible is anticipated to increase from $183 to $185. The impact was estimated at less than 0.1% for each rate cell and deemed to be immaterial.

(e) Exclusion of payments or services from the data

Consistent with the CY 2018 Prime capitation rate development, membership and expenditures related to D-SNP plans were excluded from the base data development, as Medicaid experience during D-SNP enrollment is not representative of the current Demonstration-eligible population. The July 2016 through June 2018 MMA files were used to create a monthly D-SNP eligibility list. This monthly eligibility list was matched with the Demonstration-eligible members to remove all D-SNP members and associated expenditures from the base data used in the capitation rate development. With the anticipated January 1, 2019 passive enrollment of D-SNP members, a selection factor adjustment has been applied to the Community and HCBS Waiver capitation rate cells to reflect the anticipated impact to CY 2019 Prime experience. This adjustment is discussed further in Section 3.B.

Services excluded from initial base data summaries

We excluded all services included in the encounter data that do not reflect covered benefits in the managed care program.

Adjustments made to base data

D-SNP Enrollment

Refer to the D-SNP discussion above

3. Projected benefit cost and trends

This section provides information on the development of projected benefit costs in the capitation rates.

A. RATE DEVELOPMENT STANDARDS

i. Final Capitation Rate Compliance

The final capitation rates developed are in compliance with 42 CFR 438.4(b)(6) and are only based on services outlined in 42 CFR 438.36(c)(1)(ii) and 438.3(e). CICOs do not provide any in lieu of services.

ii. Basis for Variation in Assumptions

Any assumption variation between covered populations is the result of program differences and is not based on the rate of Federal financial participation associated with the population.

iii. Benefit Cost Trend Assumptions

Projected benefit cost trend assumptions are developed in accordance with generally accepted actuarial principles and practices. The primary data used to develop benefit cost trends include historical claims and enrollment from the covered populations. Additionally, consideration of other factors and data sources appropriate for benefit cost trend development is further documented in Section I, item 3.B.iii.

iv. In Lieu Of Services

The projected benefit costs do not include costs for in lieu of services.

v. Benefit expenses associated with members residing in an IMD

IMD services are an approved part of the state plan service offerings for the Prime-eligible population; therefore no adjustment was made to the benefit expenses included in the base data.

vi. IMDs as an in lieu of service provider

Not applicable. The projected benefit costs do not include costs for in lieu of services.

B. APPROPRIATE DOCUMENTATION

i. Projected Benefit Costs

This section provides the documentation of the methodology utilized to develop the benefit cost component of the capitation rates at the rate cell level.

ii. Development of Projected Benefit Costs

(a) Description of the data, assumptions, and methodologies

This section of the report outlines the data, assumptions, and methodology used to project the benefit costs to the rating period. The baseline benefit costs were developed using the following steps:

The adjusted FFS base data year described in the previous section reflects benefits and program adjustments as of the end of the data period (December 31, 2017). Additional adjustments were made for completion and trend to the midpoint of the effective period of the capitation rates. Development of the projected benefit cost stratified by population group, region, and category of service is provided in Appendices C, D, and E

- **Step 1: Create unadjusted cost model summaries for the managed care population**

  The capitation rates were developed from historical claims and enrollment data from the Prime eligible enrolled populations. The data utilized to prepare the base period cost models consisted of CY 2017 incurred FFS data.

The historical experience was summarized by utilization per 1,000 members as well as cost per measured unit, and stratified by population rate cell and category of service. The information is summarized in Appendices C1, D1, and E1.

Historical Stratification of Covered Services

The historical expenditures were stratified using date of service, category of service, and provider type. The following provides additional details regarding the expenditures.

- **Date of Service** – The data have been stratified into calendar years. The date of service was assigned to the CY based on the first date of service. In the base data, if a hospital inpatient admission extended beyond the end of the calendar year, all days of the admission were assigned to the CY associated with the date of admission.
- **Category of Service** – Claim line detail provided by SCDHHS was used to summarize the expenditure data for the base data summaries. Milliman internal software was used to group services using detailed procedure and revenue code information for all service categories with the exception of institutional, waiver services, and IMD claims. For these expenditures, procedure code and SCDHHS-specific fund code information was used to categorize the expenditure data. Service category lines are contained within the appropriate provider types outlined below.
- **Provider Type** – Expenditures were stratified by provider type. The provider type includes inpatient hospital, outpatient hospital, physician, ancillary, and waiver services. The following provides additional information regarding the provider type.
    - Inpatient hospital services include all services performed and billed on the hospital facility claim, including any outpatient services that may have occurred in conjunction with that inpatient admission. This would include emergency room services that may have been incurred if the individual was admitted to the hospital.
        - Hospital Inpatient services were allocated to individual categories of service based on the DRG on the claim with the exception of IMD which is assigned by fund code. Utilization rates represent the number of days associated with each hospital inpatient claim.
    - Outpatient hospital services include all services performed and billed on the hospital facility claim that were not associated with an inpatient admission. These services were allocated to individual categories of service based on the procedure and revenue codes on the claim.
    - Physician services were stratified by CPT-4 code for the majority of service categories. We performed additional stratifications for physician services by CPT-4 code to provide details regarding the services provided. Utilization represents the count of claim lines for anesthesia and the number of units for all other physician services.
    - Ancillary services were stratified using HCPCS code and SCDHHS fund code information. Pharmacy services are included with the ancillary services and are identified as a separate category of service. Utilization for pharmacy services represents the number of individual prescriptions. Utilization for transportation and Incontinence Supplies represents the number of claim lines, and utilization for DME/Prosthetics and Other Ancillary services represents the number of units billed.
    - HCBS waiver services reflect non-Developmental Disability 1915(c) waiver services; including, but not limited to personal attendant, nursing, and homemaker services. The waiver services were identified using SCDHHS fund code information and were stratified using detailed procedure code information as outlined in provider manuals.

Excluded Service Categories

The following are notable service categories that are excluded from the base year data summaries. The expenditures associated with these services are not covered under the capitation rate for the Dual Demonstration population:

- Dental
- Hospice Services
- PACE Capitation Expenditures
- Medicare Premiums
- Optional State Supplemental Services
- Integrated Personal Care Services
- Intermediate Care Facilities for Individuals with Intellectual Disabilities

Hospice room and board expenditures are included in the base year data summaries as they are not specific to the hospice benefit.

In addition to the services listed above, the base data summaries exclude expenditures related to non-emergent transportation services because they were provided through a broker on a fixed-fee basis and are not included as part of the covered services, per conversations between SCDHHS and CMS. However, effective January 1, 2018, the responsibility of NEMT services applicable to nursing facility residents has been transferred to the SC Medicaid contracting nursing facilities and is reflected in the prospective adjustments described in Section 2.B.iii.(d). Unless otherwise indicated, all other claims experience from the base data period are included in the capitation rate development.

Actuarial Models

Each actuarial model illustrates annual utilization rates per 1,000, average cost per unit, and per member per month (PMPM) claims cost developed using FFS data. Appendices C through E contain actuarial models for services incurred during CY 2017, paid through September 2018. Appendices C through E also contain actuarial models for the adjusted, trended base period data as well as the final capitation rate data. The following provides a brief description of each of the data fields.

- **Annual Utilization Per 1,000** – This value represents the annual utilization rates per 1,000 by type of service. The value was calculated by dividing the total units for each service category by the member months in the corresponding period and multiplying by 12 times 1,000.
- **Average Cost per unit –** This value represents the net paid amount per unit of service. The value is assumed to be net of third party liability (TPL) recoveries and member copayments and does not include adjustments to hospital payments for DSH.
- **Member Months –** This value represents the number of enrollee months in each rate cell during each experience period. Each enrollee was assumed to be eligible for the entire month.
- **PMPM –** The per member per month (PMPM) value represents the net claim cost for each type of service. The value was calculated by multiplying the annual utilization per 1,000 times the average cost per unit and dividing by the product of 12 times 1,000.

- **Step 2: Apply historical and other adjustments to cost model summaries**

  As documented in the previous section, utilization and cost per service rates from the base experience period were adjusted for a number of items, including but not limited to: incomplete data adjustments and policy and program changes that occurred during CY 2017.

- **Step 3: Adjust for prospective program and policy changes and trend to CY 2019**

  We adjusted the CY 2017 base experience for known policy and program changes that have occurred or are expected to be implemented between the base period and the end of the CY 2019 rate period. In the previous section, we documented these items and the adjustment factors for each covered population. Assumed trend factors were applied for 24 months to the adjusted utilization and unit cost values, or per member per month (PMPM) values, as appropriate, from the midpoint of the base experience period (July 1, 2017) to the midpoint of the rate period (July 1, 2019).

  The adjustment factors documented in I.2.B.iv are applied to the historically-adjusted base period to reflect the policy and program strategies for the CY 2019 contract period. The trend rates are consistent with those documented below in I.3.D.ii.

- ***Step 4: Develop final projected PMPM for the capitation rate build-up***
  Appendices C2, D2, and E2 present the summary of the service components that establish the projected PMPM cost during CY 2019, after application of the adjustments and trends itemized above. This PMPM cost is then adjusted for estimated risk selection and 3% composite Demonstration savings by rate cell. These adjustments are presented in Appendix B. The development of the risk selection adjustment is described in the following section

Material adjustments that were previously noted

The following material adjustments were applied to recognize changes to provider reimbursement, prospective program adjustments, and changes to covered populations and were documented in the prior section (2.B. Data Adjustments):

- Nursing facility reimbursement changes
- Waiver program and reimbursement changes
- Patient liability adjustment
- Medicare Part A deductible increase
- Medicare Part B deductible increase

(b) Other material changes to the data, assumptions, and methodologies

The capitation rates calculated for CY 2019 reflect a complete rebasing of claims and assumptions compared to the CY 2018 capitation rates. Additionally, the base data has been reduced from a blending of two years in the CY 2018 capitation rates to one year in the CY 2019 capitation rates as a result of limitations on the availability of monthly historical MMA data files. Other material changes include the selection factor related to January 1, 2019 D-SNP passive enrollment and the application of non-benefit cost expenses to the CY 2019 capitation rates. The demonstration savings of 3% is assumed to remain consistent in CY 2019.

Individuals enrolled in Prime are primarily assigned through passive enrollment. The Prime program began passively enrolling individuals into Prime in April 2016, followed by additional waves of passive enrollment in late 2016 and monthly waves in August 2017 forward.

The selection factor accounts for cost differences between the members included in the CY 2017 base data and the following:

- Individuals enrolled in the Demonstration; and,
- Individuals anticipated to enroll through passive enrollment during CY 2019.

We reviewed the Community, Nursing Facility and HCBS Waiver rate cells separately for the assumed cost differential impact attributed to each of these populations.

Community Rate Cell

To estimate the impact of cost differences of individuals enrolled in the Demonstration in the Community rate cell, we compared historical CY 2017 PMPM costs of members enrolled in the Demonstration and the Prime-eligible population represented by the unadjusted base data. As a result of this review, the observed cost profiles for these two populations were similar, therefore a selection factor for the current Community population was not necessary. This observation is consistent with our observation in the CY 2018 Prime capitation rate development.

In addition to the current Community population, we reviewed the cost differences of D-SNP members anticipated to enroll through passive enrollment, relative to the CY 2017 base data. Effective January 1, 2019, SCDHHS is anticipated to passively enroll approximately 8,000 D-SNP members (6,600 Community/1,400 HCBS Waiver) into the Prime program. Based on the observed data of previous passive enrollment waves, the effective annual opt-out rate for passively-enrolled members is approximately 37%. However, we have assumed that the opt-out rate for incoming D-SNP members will be higher than 37%, as a result of member familiarity with their current D-SNP and the potential for D-SNPs to encourage member retention in 2019. We have assumed the opt-out rate to be 1.5 times the observed values for the prior passive enrollment waves, at approximately 56%.

Our review of the historical utilization and cost differences in the CY 2017 FFS data between D-SNP members and the unadjusted CY 2017 base data indicated that the cost profile for D-SNP members is approximately 35% lower than the CY 2017 base data.

The combined impact of the current Prime enrollees and the anticipated passive enrollment of current D-SNP members results in a selection factor of 0.921 applied to the total Community PMPM benefit cost, after application of trend, program changes, and rating period adjustments. Figure 4 illustrates the development of the Community rate cell selection factor.

FIGURE 4: Community - Selection Factor Development

		Passive Enrollment Impact				
Population	Projected Jan 1, 2019 Membership	Passive Enrollment	Effective Annual Opt-Out	DSNP Retention Multiplier	Estimated Average CY 2019 Membership	Morbidity Relativity
DSNP Passive	-	6,610	0.37	1.50	2,941	0.65
Other Passive	-	1,080	0.37	N/A	680	1.00
Current Prime	9,378	N/A	N/A	N/A	9,378	1.00
Composite	**9,378**				**12,999**	**0.921**

Notes:
1. D-SNP passive enrollment counts based on member eligibility files provided by SCDHHS
2. Other passive enrollment counts reflect enrollment resulting from newly-eligible passive enrollment counties (Anderson, Cherokee, Greenwood, Oconee)
3. Current Prime enrollment based on September 1, 2018 enrollment

Nursing Facility Rate Cell

The majority of service costs for the Nursing Facility population is determined by the nursing facility services, and our review of historical data for this populations indicates that a risk selection factor of 1.00 is appropriate, primarily based on our observation of low credibility for Prime-enrolled Nursing Facility members. Additionally, D-SNP members are ineligible for passive enrollment into the Nursing Facility rate cell, therefore a selection factor was not relevant for the anticipated January 1, 2019 passive enrollment.

HCBS Waiver Rate Cell

To estimate the impact of cost differences of individuals enrolled in the Demonstration in the HCBS Waiver rate cell, we compared historical utilization and cost differences in the CY 2017 FFS data between members currently enrolled in the HCBS Waiver rate cell (as of September 2018) and the unadjusted CY 2017 base data. We observed that individuals enrolled in Prime exhibited higher utilization of waiver services than those Prime-eligible individuals in the base data who have not enrolled in the Prime program.

Because CY 2017 FFS experience does not exist for currently-enrolled HCBS Waiver members who joined the Prime program prior to January 1, 2017, we utilized the HCBS Waiver selection factor developed for the CY 2018 capitation rates (using CY 2016 base data) to assess the relative morbidity of these members. The CY 2017 FFS experience for currently-enrolled HCBS Waiver members was used to assess the relative morbidity for members who joined the Prime program after January 1, 2017. As such, a selection factor of 1.045 has been applied to the total HCBS Waiver PMPM cost after application of trend, program changes, and rating period adjustments. Note that our review of FFS data for the anticipated DSNP members eligible for passive enrollment indicates a morbidity factor of approximately 1.0 relative to the current Prime-enrolled population. Figure 5 illustrates the development of the HCBS Waiver rate cell selection factor.

FIGURE 5: HCBS Waiver - Selection Factor Development

Population	Projected Jan 1, 2019 Membership	Passive Enrollment Impact: Passive Enrollment	Passive Enrollment Impact: Effective Annual Opt-Out	Passive Enrollment Impact: DSNP Retention Multiplier	Estimated Average CY 2019 Membership	Morbidity Relativity
DSNP Passive	-	1,362	0.37	1.50	606	1.000
Other Passive	-	233	0.37	N/A	147	1.021
Current Prime						
Effective prior to 1/1/17	1,131	N/A	N/A	N/A	1,131	1.085
Effective after 1/1/17	586	N/A	N/A	N/A	586	1.021
Composite	**1,717**				**2,470**	**1.045**

Notes:
1. D-SNP passive enrollment counts based on member eligibility files provided by SCDHHS
2. Other passive enrollment counts reflect enrollment resulting from newly-eligible passive enrollment counties (Anderson, Cherokee, Greenwood, Oconee) provided by SCDHHS
3. D-SNP morbidity relativity assumed to equal 1.0 based on observed comparison of CY 2017 D-SNP experience and CY 2017 unadjusted base data

iii. Projected Benefit Cost Trends

This section discusses the data, assumptions, and methodologies used to develop the benefit cost trends, i.e., the annualized projected change in benefit costs from the historical base period (CY 2017) to the CY 2019 rating period of this certification. We evaluated prospective trend rates using historical experience for the South Carolina FFS program, as well as external data sources.

We developed trend rate assumptions for the populations and services covered under the Prime program based on claims experience data from January 1, 2015 through December 31, 2017. Utilization, cost per unit, and PMPM costs were summarized for the experience period by incurred month, rate cell, and medical service category. For utilization and cost per unit, separate trend rates were developed by population and medical service category. Cost per unit trend rates are reflective of both changes in the unit cost of a given medical service and changes in the mix or intensity of services over time within a given medical service category.

(a) Required elements

(i) Data

The primary source of data used in the development of historical fee-for-service trends was January 1, 2015 through December 31, 2017 FFS data specific to the Prime eligible population.

External data sources that were referenced include:

- National Health Expenditure (NHE) projections developed by the CMS office of the actuary, specifically those related to Medicaid. Please note that as these are expenditure projections, projected growth reflects not only unit cost and utilization, but also aggregate enrollment growth and enrollment mix changes such as aging. NHE tables and documentation may be found in the location listed below:
  - https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html
- *Other sources:* We also reviewed internal sources that are not publicly available, such as historical experience from other programs and trends used by other Milliman actuaries.

(ii) Methodology

Trends were estimated for the CY 2019 capitation rates based on analysis of historical trend rates and 12-, 18-, and 24-month linear regression trends (using claims experience data incurred from January 1, 2015 through December 31, 2017, and paid through September 2018). Utilization, cost per unit, and per member per month costs were summarized for the experience period by incurred month, rate cell, and major category of service. Claims completion factors were applied to the base experience period utilization and expenditures using standard actuarial methodologies.

Monthly historical experience was normalized for policy and program changes and reimbursement adjustments to reflect a consistent level of benefits and reimbursement across the historical time period. Cost per unit trend rates are reflective of both changes in the unit cost of a given medical service and changes in the mix or intensity of services within a given medical service category.

Trend rate development was supported by historical claims and eligibility experience for the Prime-eligible population. Rolling 12-month and 6-month trends were calculated to identify changes in the underlying patterns over time, and two-year annualized trends were reviewed to smooth out significant fluctuations from year to year.

(iii) Comparisons

Historical trends should not be used in a simple formulaic manner to determine future trends; a great deal of actuarial judgment is also needed.

We did not explicitly rely on the historical data trend projections due to anomalies observed in the historical trend data and patterns that we do not expect to continue over the long-term. We referred to the sources listed in the prior section, considered changing practice patterns, the impact of reimbursement changes on utilization in the Prime eligible population, and shifting population mix.

Explicit adjustments were made outside of trend to reflect all recent or planned changes in reimbursement from the base period to the rating period.

(b) Benefit cost trend components

Figure 6 provides the assumed annual trend rates by category of service and population that were applied to the base period data in the development of the capitation rates for the Prime program.

FIGURE 6: Annual Trend Rate Assumptions

	Community		Nursing Facility		HCBS Waiver	
Category of Service	Utilization	Cost Per Service	Utilization	Cost Per Service	Utilization	Cost Per Service
Inpatient	0.00%	0.50%	0.00%	0.50%	0.00%	0.50%
Outpatient	1.00%	2.50%	1.00%	2.50%	1.00%	2.50%
Institutional	1.00%	0.25%	1.00%	0.25%	1.00%	0.25%
Physician	1.00%	2.50%	1.00%	2.50%	1.00%	2.50%
Pharmacy	1.00%	0.50%	1.00%	0.50%	1.00%	0.50%
Ancillaries	1.00%	2.50%	1.00%	2.50%	1.00%	2.50%
Waiver Services	2.00%	0.00%	2.00%	0.00%	2.00%	0.00%

(c) Variation

To limit the variation in benefit cost that is present across the Medicaid population as a whole, we developed trends by major category of service. Because of low utilization outside their respective rate cells, the observed institutional trends for the Nursing Facility population and waiver trends for HCBS Waiver population were applied to all populations.

(d) Material adjustments

We made explicit adjustments to the historical data analyzed for trends in an effort to normalize the data for historical reimbursement adjustments and changing populations to extract underlying trend information; however, there were still anomalies that were present in the data and contributed to unreasonable trend patterns.

As a result, we used actuarial judgment to adjust the trends derived from historical experience in cases where the resulting trends did not appear reasonably sustainable, or were not within consensus parameters derived from other sources.

For many rate cells and categories of services, raw model output was outside of a range of reasonable results. In these situations, we relied on the sources identified to develop prospective trend.

(e) Any other adjustments

(i) Impact of managed care

We did not adjust the trend rates to reflect a managed care impact on utilization or unit cost. The capitation rates have an explicit adjustment for the Demonstration savings assumed under mutual agreement in the Memorandum of Understanding (MOU).

(ii) Trend changes other than utilization and cost

We did not adjust the benefit cost trend for changes other than utilization or unit cost.

iv. Mental Health Parity and Addiction Equity Act Service Adjustment

No adjustment was made to reflect Mental Health Parity.

v. In Lieu of Services

The projected benefit costs do not include costs for in lieu of services.

vi. Retrospective Eligibility Periods

(a) MCO responsibility

The projected benefit costs do not include an adjustment for retrospective eligibility.

(b) Claims treatment

No base data adjustment was included for retrospective eligibility.

(c) Enrollment treatment

Enrollment is treated consistently with claims. We have not adjusted for retrospective eligibility.

(d) Adjustments

No adjustments to the rates for retrospective eligibility periods were applied.

vii. Impact of Material Changes

Material changes to required provider payments have been described in program adjustments described in Section 2.B.iii.(d) Program Change Adjustments. We have made adjustments for the following program change since the July 2018 rate certification:

- CY 2019 Medicare Part A deductible increase.

(a) Change to covered benefits

There were no material changes related to covered benefits.

(b) Recoveries of overpayments

There were no material changes related to recoveries of overpayments.

(c) Change to payment requirements

An adjustment was made for the CY 2019 Medicare Part A deductible increase, effective January 1, 2019.

(d) Change to waiver requirements

There were no material changes related to waiver requirements or conditions.

(e) Change due to litigation

There were no material changes due to litigation.

viii. Documentation of Material Changes

Material changes to covered benefits and provider payments have been described in program adjustments described in Section I, item 2.B.iii.(d) Program Change Adjustments. This information includes the data, assumptions, and methodology used in developing the adjustment, estimated impact by population, and aggregate impact on the managed care program's benefit expense. Non-material changes to covered benefits or provider payments have also been described in that section of the report.

4. Special Contract Provisions Related to Payment

A. INCENTIVE ARRANGEMENTS

i. Rate Development Standards

There are no incentive arrangements in the South Carolina Healthy Connections Prime program.

ii. Appropriate Documentation

There are no incentive arrangements in the South Carolina Healthy Connections Prime program.

B. WITHHOLD ARRANGEMENTS

i. Rate Development Standards

This section provides documentation of the withhold arrangement in the South Carolina Healthy Connections Prime program.

ii. Appropriate Documentation

(a) Description of the Withhold Arrangement

(i) Time period and purpose

The withhold arrangement is measured on a demonstration year basis. The withhold measure evaluates quality-based performance and technical data quality requirements.

(ii) Description of total percentage withheld

SCDHHS has established a quality withhold of 3.0% of the capitation rate for CY 2019, and will determine the return of the withhold based on review of each CICO's HEDIS data and the CICO's compliance with the quality measures established in each CICO's contract with SCDHHS.

The capitation rates shown in this letter are illustrated before offset for the withhold amount; however, the CY 2019 capitation rates documented in this report are actuarially sound after adjustment for the amount of the withhold not expected to be earned.

(iii) Estimate of percent to be returned

In Demonstration year 2 (January 2017 through December 2017), the CICOs in aggregate are estimated to receive approximately 100% of available withhold funds from SCDHHS. Although additional quality withhold measures were implemented for years 3 and 4 of the Demonstration, the estimated amount of the withhold return attainable is assumed to remain at 100%.

(iv) Reasonableness of withhold arrangement

Our review of the total withhold percentage of 3.0% of capitation revenue indicates that it is reasonable within the context of the capitation rate development and the magnitude of the withhold does not have a detrimental impact on the health plan's financial operating needs and capital reserves. Our interpretation of financial operating needs relates to cashflow needs for the health plan to pay claims and administer benefits for its covered population. We evaluated the reasonableness of the withhold within this context by reviewing the health plan's cash available to cover operating expenses, as well as the capitation rate payment mechanism utilized by SCDHHS. To evaluate the reasonableness of the withhold in relation to capital reserves, we reviewed each health plan's risk-based capital ratio. The data source utilized to calculate these metrics was each plan's calendar year 2017 NAIC annual statement.

(1) Risk-Based Capital (RBC) Levels: RBC levels were reviewed to assess surplus levels and financial stability of each CICO to pay all policyholder obligations. Surplus levels for CY 2017 are strong, with RBC-levels for each CICO at or greater than 275%.

Although 100% of the withhold is assumed to be reasonably achieved, stress-testing the capital levels for each CICO with the full amount of the 3.0% withhold does not reduce the RBC ratio to a level that would trigger regulatory action.

MCO Financial Review	
Health Plan	**RBC Level**
Absolute Total Care	380.0%
Molina	277.7%
Select Health	361.6%

Source: CY 2017 NAIC Annual Statement ('Five-Year Historical Data', Page 29)

(2) Cash available for operating expenses: We reviewed cash and cash equivalent levels in relation to the withhold arrangement. We believe the withhold arrangement is reasonable based on current cash levels and the following withhold level and SCDHHS payment timing:

- A 3.0% withhold over the CY is equivalent to approximately 11 days of revenue.
- SCDHHS makes capitation payments to MCOs at the beginning of each month (which essentially "pre-pays" the expected claims for the month), contributing favorably to monthly cash flow needs.

(v) Effect on the capitation rates

The CY 2019 certified capitation rates reflect the expectation that 100% of the withhold is reasonably achievable.

C. RISK SHARING MECHANISMS

i. Rate Development Standards

This section provides documentation of the risk-sharing mechanisms in the South Carolina Healthy Connections Prime program.

ii. Appropriate Documentation

(a) Description of Risk-sharing Mechanism

The Medicaid component of the Prime capitation rates was developed for a full-risk managed care program. The CICOs assume risk for the cost of services covered under the contract and incur losses if the cost of furnishing the services exceeds the payments under the contract.

(b) Medical Loss Ratio

Description

Each CICO will be required annually to meet a medical loss ratio (MLR) threshold which regulates the minimum amount (as a percentage of the gross joint Medicare and Medicaid payments) that must be used for expenses either directly related to medical claims or those which are related to the care and quality of enrollees. This will be established at 85%. Additional detail related to the MLR can be found in the three-way contract between SCDHHS, CMS, and the participating CICOs.

Financial consequences

If a CICO has an MLR below eighty-five percent (85%) of the joint Medicare and Medicaid payment, the CICO must remit the amount by which the eighty-five percent (85%) threshold exceeds the CICOs actual MLR multiplied by the coverage year revenue. Any collected remittances would be distributed proportionally back to the Medicaid and Medicare programs on a percent of premium basis. CMS and SCDHHS may then choose, separately, whether the CICO may make a payment or by an offset to future capitation payment.

(c) Reinsurance Requirements and Effect on Capitation Rates

There are no reinsurance requirements for CICOs contracted with SCDHHS for the Healthy Connections Prime program.

D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

i. Rate Development Standards

The base data used in the development of the capitation rates is developed from FFS claims and membership. There are no adjustments to the base data to reflect any requirements for the managed care plans to direct provider reimbursement that differs from the FFS delivery system. The Healthy Connections Prime capitation rates are to be developed "in absence of the Demonstration," therefore no adjustments for provider payment initiatives would be applicable to the Prime Program.

ii. Appropriate Documentation

Not applicable - The Healthy Connections Prime capitation rates are to be developed "in absence of the Demonstration," therefore no adjustments for provider payment initiatives would be applicable to the Prime Program.

(i) Description of delivery system and provider payment Initiatives included in the capitation rates

Not applicable. The Healthy Connections Prime capitation rates are to be developed "in absence of the Demonstration," therefore no adjustments for provider payment initiatives would be applicable to the Prime Program

(ii) Amount of delivery system and provider payment Initiatives included in the capitation rates

Not applicable.

(iii) Providers receiving delivery system and provider payment initiatives

Not applicable.

(iv) Effect of delivery system and provider payment Initiatives on development of capitation rates

Not applicable.

(v) Description of consistency with 438.6(c) preprint

Not applicable.

E. PASS-THROUGH PAYMENTS

This section is not applicable because there are no pass-through payments for the Prime program.

i. Rate Development Standards

This section is not applicable because there are no pass-through payments for the Prime program.

ii. Appropriate Documentation

(a) Description of Pass-Through Payments

(i) Description

This section is not applicable because there are no pass-through payments for the Prime program.

(ii) Amount

This section is not applicable because there are no pass-through payments for the Prime program.

(iii) Providers receiving the payment

This section is not applicable because there are no pass-through payments for the Prime program.

(iv) Financing mechanism

This section is not applicable because there are no pass-through payments for the Prime program.

(v) Pass-through payments for previous rating period

This section is not applicable because there are no pass-through payments for the Prime program.

(vi) Pass-through payments for rating period in effect on July 5, 2016

This section is not applicable because there are no pass-through payments for the Prime program.

(b) Hospital Pass-Through Payments

Not applicable. There are no hospital pass-through payments in the South Carolina Healthy Connections Prime program.

5. Projected non-benefit costs

A. RATE DEVELOPMENT STANDARDS

i. Overview

Based on guidance from SCDHHS and the joint rate-setting process for the Financial Alignment's Capitated Model initiative, the non-benefit component of the capitation rate reflects the estimated non-benefit costs for Healthy Connections Prime members while in the FFS program (i.e., "absent the demonstration").

The basis for Medicaid rates began with costs developed prior to the application of the Medicare and Medicaid composite savings percentages established by the State and CMS, informed by estimates from CMS and its contractors. The final Medicaid capitation rates were established by applying composite savings percentages established by the State and CMS and documented in the MOU to both the benefit and non-benefit component of the capitation rates.

The remainder of Section I, item 5 provides documentation of the data, assumptions and methodology that we utilized to develop the non-benefit cost component of the capitation rate.

ii. PMPM versus percentage

The non-benefit cost was developed as a PMPM estimate.

iii. Basis for variation in assumptions

Any assumption variation between covered populations is the result of program differences and is in no way based on the rate of federal financial participation associated with the population.

iv. Health insurance providers fee

There is no allocation in the rate development for purposes of the Health Insurer Fee (HIF). As these rates are to be developed "in absence of the Demonstration," no HIF would be applicable under a FFS arrangement.

B. APPROPRIATE DOCUMENTATION

i. Development of non-benefit costs

(a) Description of the data, assumptions, and methodologies

Data

The primary data sources used in the development of the CY 2019 non-benefit costs are the CY 2017 quarterly Form CMS-64 reports provided by SCDHHS. Form CMS-64.9 was used to identify quarterly Medicaid Assistance expenditures, excluding administrative expenses, and Form CMS-64.10 was used to identify quarterly Medicaid Assistance administrative expenses.

(b) Material changes

The inclusion of non-benefit costs to the Healthy Connections Prime capitation rates is a material change from the CY 2018 rate development. Based on guidance from SCDHHS and our review of other dual demonstration programs where FFS is absent the demonstration and an allowance for non-benefit costs has been included, an adjustment to the capitation rate is made to reflect the estimated administrative costs incurred by SCDHHS absent the demonstration.

(c) Other material adjustments

There are no other material adjustments applicable to the non-benefit cost component of the capitation rate.

ii. Non-benefit costs, by cost category

Administrative expenses have not been developed from the ground up (based on individual components). We relied on Form CMS-64 reports to estimate the average administrative expense PMPM for the Medicaid program, which is estimated at approximately $23 PMPM. Figure 7 illustrates the non-benefit cost PMPMs by rate cell for the CY 2019 Healthy Connections Prime program.

FIGURE 7: Non-Benefit Cost Allowance by Rate Cell

Rate Cell	Total
Community	$ 9.00
Nursing Facility	$ 90.00
HCBS Waiver	$ 90.00
HCBS Waiver Plus	$ 90.00

The estimated non-benefit costs by rate cell were weighted by CY 2019 projected member months as provided in Figure 1 to develop a composite PMPM of approximately $22.57, which is generally consistent with the overall FFS administrative expense PMPM average of $23 developed from Form CMS-64 repots.

The application of the non-benefit cost allowance in the capitation rate development is presented in Appendix B.

iii. Health insurance providers fee

(a) Whether the fee is incorporated in the rates

There is no allocation in the rate development for purposes of the Health Insurer Fee (HIF). As these rates are to be developed “in absence of the Demonstration,” no HIF would be applicable under a FFS arrangement.

(b) Fee year or data year

This section is not applicable because there is no specific allowance for HIF in the development of the Prime capitation rates.

(c) Determination of fee impact to rates

This section is not applicable because there is no specific allowance for HIF in the development of the Prime capitation rates.

(d) Timing of adjustment for health insurance providers fee

This section is not applicable because there is no specific allowance for HIF in the development of the Prime capitation rates.

(e) Identification of long-term care benefits

This section is not applicable because there is no specific allowance for HIF in the development of the Prime capitation rates.

(f) Application of health insurance providers fee in 2014, 2015, and 2016 capitation rates

This section is not applicable because there is no specific allowance for HIF in the development of the Prime capitation rates.

6. Risk Adjustment and Acuity Adjustments

This section is not applicable as no specific risk adjustment is being applied to the Prime capitation rates at this time.

Section II. Medicaid Managed care rates with long-term services and supports

1. Managed Long-Term Services and Supports

A. COMPLETION OF SECTION I

Prime is South Carolina's managed care program for the dual eligible (Medicare-Medicaid) population. Eligible individuals are required to either receive both Medicare and Medicaid services through the managed care plan or opt-out to fee-for-service. A significant portion of services provided to these members are long-term services and support (LTSS) including nursing facility, home care, and home and community based (HCBS) waiver services.

We completed Section I of this report for MLTSS and other medical services.

B. MLTSS RATE STRUCTURE

(a) Capitation rate structure

The Prime rate structure for CY 2019 is consistent with the 2015 through 2018 capitation rates. Refer to Section I.1.A.ii.(c).(iii) for additional details related to the covered populations and rate structure criteria.

(b) Methodology

The structure, rationale, and payment methodology are discussed in Section I.1.A.ii of this report. The rate cell structure has been approved for the Demonstration and is not subject to a blended rate structure.

C. MANAGED CARE EFFECT

The rate cell structure encourages CICOs to manage the population towards lower cost settings by way of the transitional case rate (i.e., "Plus" rates). This is the basis for management efficiencies in MLTSS programs. This transition between settings (e.g. nursing facility to HCBS waiver services) is gradual in nature and is not an immediate transition. Most often, individuals who reside in a nursing facility for a long period of time have lost their community supports and it becomes difficult to change the setting away from a nursing facility.

D. NON-BENEFIT COST

Section I, Item 5 details the assumptions used in the development of the non-benefit costs for the MLTSS population in the Prime program.

E. EXPERIENCE AND ASSUMPTIONS

Section I details the experience and assumptions employed for the MLTSS and non-MLTSS services included in the Prime program.

Section III. New adult group capitation rates

Section III of the CMS Guide is not applicable to the SCDHHS Healthy Connections Prime program.

Limitations

The information contained in this letter was prepared as documentation of the actuarially sound capitation rates for the Medicaid managed care program in the State of South Carolina. The information may not be appropriate for any other purpose.

The information contained in this letter, including the enclosures, has been prepared for SCDHHS and their consultants and advisors. It is our understanding that the information contained in this letter will be shared with CMS and may be utilized in a public document. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for SCDHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

Although the capitation rates have been certified as actuarially sound, the capitation rates may not be appropriate for any individual CICO. Results will differ if actual experience is different from the assumptions contained in the capitation rate setting documentation. SCDHHS and Milliman provide no guarantee, either written or implied, that the data and information is 100% accurate or error free.

Milliman has relied on information provided by SCDHHS and the participating Medicaid CICOs in the development of the CY 2019 capitation rates. We have relied upon SCDHHS and the MCOs for the accuracy of the data and accept it without audit. To the extent that the data provided are not accurate, the capitation rate development would need to be modified to reflect revised information.

The services provided by Milliman to SCDHHS were performed under the signed consulting agreement between Milliman and SCDHHS effective July 1, 2018.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

Appendix A: Actuarial certification

State of South Carolina
Department of Health and Human Services
Healthy Connections Prime Program – Medicaid Component
Capitation Rates Effective January 1, 2019 through December 31, 2019

Actuarial Certification

I, Marlene T. Howard, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been employed by the State of South Carolina and am generally familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions.

Assessment of actuarial soundness, in the context of Prime, should consider both Medicare and Medicaid contributions and the opportunities for efficiencies unique to an integrated care program. CMS considers the Medicaid actuarial soundness requirements to be flexible enough to consider efficiencies and savings that may be associated with Medicare. Therefore, CMS does not believe that a waiver of Medicaid actuarial soundness principles is necessary in the context of this Demonstration. The capitation rates provided with this certification are considered "actuarially sound" for purposes of 42 CFR 438.4(a), according to the following criteria:

- the capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the CICO for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).

For the purposes of this certification and consistent with the requirements under 42 CFR 438.4(a), "actuarial soundness" is defined as in ASOP 49:

"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes."

The assumptions used in the development of the "actuarially sound" capitation rates have been documented in my correspondence with the State of South Carolina. In the development of the capitation rates for the Prime program, I relied on regulatory guidance related to the capitation rate setting methodology and the mandatory joint savings percentage required by the three-way contract. The "actuarially sound" capitation rates that are associated with this certification are effective for the rate period January 1, 2019 through December 31, 2019.

The capitation rates are considered actuarially sound after adjustment for the amount of the withhold not expected to be earned.

The "actuarially sound" capitation rates are based on a projection of future events. Actual experience may be expected to vary from the experience assumed in the rates.

In developing the "actuarially sound" capitation rates, I have relied upon data and information provided by the State. I have relied upon the State for audit of the data. However, I did review the data for reasonableness and consistency.

The capitation rates developed may not be appropriate for any specific health plan. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The health plan may require rates above, equal to, or below the "actuarially sound" capitation rates that are associated with this certification.

Marlene T. Howard, FSA
Member, American Academy of Actuaries

September 10, 2019
Date

Appendix B: Capitation Rate Summary

South Carolina Department of Health and Human Services
Calendar Year 2019 Healthy Connections Prime Capitation Rate Development
Calendar Year 2019 Capitation Rate Summary

Population	Estimated CY 2019 Member Months	Jul - Dec 2018 Capitation Rate	Calendar Year 2019 Rates: Projected PMPM Before Selection	Selection Factor	Projected Baseline Rate	Estimated Patient Liability	Projected Rate (Net of Patient Liability)	Administrative Costs	Demonstration Savings Factor	CY 2019 Capitation Rate	Percent Increase	CY 2019 Estimated Impact
Community	155,988	$ 86.00	$ 87.00	0.921	$ 80.11	$ 0.00	$ 80.11	$ 9.00	0.97	$ 86.44	0.5%	$ 69,000
Nursing Facility	1,740	5,488.45	5,669.77	1.000	5,669.77	1,008.56	4,661.21	90.00	0.97	5,617.24	2.3%	224,000
HCBS Waiver	28,740	1,237.72	1,231.53	1.045	1,287.05	-	1,287.05	90.00	0.97	1,335.74	7.9%	2,817,000
Waiver Plus	900	3,480.32	3,710.16		3,710.16	-	$ 3,710.16		0.97	3,598.85	3.4%	107,000
Composite	***187,368***	***$ 329.13***	***$ 331.80***		***$ 334.58***		***$ 325.22***			***$ 346.30***	***5.2%***	***$ 3,217,000***

1. Projected Baseline Rate: Illustrates the estimated Medicaid benefit cost to the state absent the dual demonstration on a per member per month basis.
2. CY 2019 Capitation Rate: (Projected Rate (Net of Patient Liability) + Administrative Costs) x Demonstration Savings Factor + Estimated Patient Liability
3. The Waiver Plus rate is estimated as the HCBS waiver rate plus 2/3 of the difference between the institutional portion of the Nursing Facility rate net of patient liability and the waiver services component of the HCBS Waiver capitation rate, adjusted for the selection factor.
4, The administrative costs for the Waiver Plus rate are included in the projected baseline rate as a result of the Waiver Plus rate calculation documented in item 3.
5. 1/1/19 anticipated passive enrollment is included in the estimated CY 2019 member months.

Appendix C: Capitation Rate Development - Community

South Carolina Department of Health and Human Services
Calendar Year 2019 Healthy Connections Prime Capitation Rate Development
FFS Base Experience Data Adjustments - Calendar Year 2017
Paid through September 2018

Rate Cell: Community		2017 FFS Base Experience			Data Adjustments	Program and Policy Adjustments		2017 FFS Adjusted Experience		
Experience Member Months:	**164,343**									
Category of Service		**Utilization per 1,000**	**Cost per Service**	**PMPM**	**Completion Adjustment**	**Utilization Adjustment**	**Cost Adjustment**	**Utilization per 1,000**	**Cost per Service**	**PMPM**
Inpatient Hospital										
Inpatient Medical/Surgical/Non-Delivery		1,034.9	$ 279.40	$ 24.10	1.0102	1.0000	1.0000	1,045.5	$ 279.40	$ 24.34
Inpatient MH/SA		86.3	310.03	2.23	1.0102	1.0000	1.0000	87.2	310.03	2.25
Other Inpatient		-	-	-	1.0102	1.0000	1.0000	-	-	-
Subtotal Inpatient Hospital				**$ 26.33**						**$ 26.59**
Outpatient Hospital										
Surgery		140.1	$ 181.54	$ 2.12	1.0322	1.0000	1.0000	144.6	$ 181.54	$ 2.19
Non-Surg - Emergency Room		249.0	63.39	1.32	1.0322	1.0000	1.0000	257.0	63.39	1.36
Non-Surg - Other		230.2	21.67	0.42	1.0322	1.0000	1.0000	237.6	21.67	0.43
Observation Room		18.1	46.40	0.07	1.0322	1.0000	1.0000	18.7	46.40	0.07
Treatment/Therapy/Testing		514.0	79.83	3.42	1.0322	1.0000	1.0000	530.5	79.83	3.53
Other Outpatient		27.5	74.82	0.17	1.0322	1.0000	1.0000	28.3	74.82	0.18
Subtotal Outpatient Hospital				**$ 7.51**						**$ 7.75**
Institutional										
DHHS Nursing Home		1,279.5	$ 151.10	$ 16.11	1.0212	1.0000	1.0268	1,306.7	$ 155.14	$ 16.89
DMH Nursing Home		9.0	242.61	0.18	1.0212	1.0000	1.0195	9.2	247.33	0.19
Nursing Home Swing Beds		-	-	-	1.0212	1.0000	1.0000	-	-	-
Hospice Room & Board		93.9	144.63	1.13	1.0212	1.0000	1.0280	95.9	148.69	1.19
Subtotal Institutional				**$ 17.42**						**$ 18.27**
Professional										
Inpatient and Outpatient Surgery		520.6	$ 26.35	$ 1.14	1.0121	1.0000	1.0000	526.9	$ 26.35	$ 1.16
Anesthesia		130.1	19.54	0.21	1.0121	1.0000	1.0000	131.7	19.54	0.21
Inpatient Visits		1,554.3	20.63	2.67	1.0121	1.0000	1.0000	1,573.1	20.63	2.70
MH/SA		2,166.7	11.41	2.06	1.0121	1.0000	1.0000	2,193.0	11.41	2.09
Emergency Room		199.9	32.19	0.54	1.0121	1.0000	1.0000	202.3	32.19	0.54
Office/Home Visits/Consults		3,117.2	29.64	7.70	1.0121	1.0000	1.0000	3,155.0	29.64	7.79
Pathology/Lab		709.1	3.63	0.21	1.0121	1.0000	1.0000	717.7	3.63	0.22
Radiology		872.3	14.64	1.06	1.0121	1.0000	1.0000	882.9	14.64	1.08
Office Administered Drugs		31,807.4	2.21	5.85	1.0121	1.0000	1.0000	32,193.3	2.21	5.92
Physical Exams		28.3	17.40	0.04	1.0121	1.0000	1.0000	28.6	17.40	0.04
Therapy		136.3	4.04	0.05	1.0121	1.0000	1.0000	138.0	4.04	0.05
Vision		174.4	26.95	0.39	1.0121	1.0000	1.0000	176.5	26.95	0.40
Other Professional		2,750.1	6.40	1.47	1.0121	1.0000	1.0000	2,783.4	6.40	1.48
Subtotal Professional				**$ 23.39**						**$ 23.68**
Ancillary										
Prescription Drugs		474.0	$ 7.83	$ 0.31	1.0000	1.0000	1.0000	474.0	$ 7.83	$ 0.31
Transportation		38.6	26.44	0.08	1.0536	1.0000	1.0000	40.6	26.44	0.09
DME/Prosthetics		10,831.9	3.70	3.34	1.0536	1.0000	1.0000	11,412.7	3.70	3.52
Incontinence Supplies		427.5	31.33	1.12	1.0536	1.0000	1.0000	450.4	31.33	1.18
Other Ancillary		1,128.1	6.70	0.63	1.0536	1.0000	1.0000	1,188.6	6.70	0.66
Subtotal Ancillary				**$ 5.48**						**$ 5.76**
Waiver Services										
Personal Care I (General Housekeeping)		41.8	$ 13.71	$ 0.05	1.0000	1.0000	1.0000	41.8	$ 13.71	$ 0.05
Personal Care II - Homemaker		44.0	23.84	0.09	1.0000	1.0000	1.0000	44.0	23.84	0.09
Attendant/Companion		3.1	28.32	0.01	1.0000	1.0000	1.0000	3.1	28.32	0.01
PA, RN, LPN, CNA Providers and Therapies		-	-	-	1.0000	1.0000	1.0000	-	-	-
Home Delivered Meals		12.1	37.05	0.04	1.0000	1.0000	1.0000	12.1	37.05	0.04
Adult Day Health Care		4.5	52.22	0.02	1.0000	1.0000	1.0000	4.5	52.22	0.02
Case Management		15.6	68.60	0.09	1.0000	1.0000	1.0507	15.6	72.08	0.09
Other Waiver Services		9.0	36.06	0.03	1.0000	1.0000	1.0000	9.0	36.06	0.03
Subtotal Waiver Services				**$ 0.32**						**$ 0.32**
Total Medical Cost				**$ 80.45**						**$ 82.37**

South Carolina Department of Health and Human Services
Calendar Year 2019 Healthy Connections Prime Capitation Rate Development
January 2019 to December 2019 Capitation Rates

Rate Cell: Community	2017 FFS Adjusted Experience			Trend Adjustments		Program and Policy Adjustments		CY 2019 Capitation Rate		
Category of Service	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital										
Inpatient Medical/Surgical/Non-Delivery	1,045.5	$ 279.40	$ 24.34	1.0000	1.0100	1.0000	1.0249	1,045.5	$ 289.21	$ 25.20
Inpatient MH/SA	87.2	310.03	2.25	1.0000	1.0100	1.0000	1.0037	87.2	314.29	2.28
Other Inpatient	-	-	-	1.0000	1.0100	1.0000	1.0000	-	-	-
Subtotal Inpatient Hospital			**$ 26.59**							**$ 27.48**
Outpatient Hospital										
Surgery	144.6	$ 181.54	$ 2.19	1.0201	1.0506	1.0000	1.0000	147.5	$ 190.73	$ 2.34
Non-Surg - Emergency Room	257.0	63.39	1.36	1.0201	1.0506	1.0000	1.0000	262.2	66.59	1.45
Non-Surg - Other	237.6	21.67	0.43	1.0201	1.0506	1.0000	1.0000	242.3	22.77	0.46
Observation Room	18.7	46.40	0.07	1.0201	1.0506	1.0000	1.0000	19.1	48.75	0.08
Treatment/Therapy/Testing	530.5	79.83	3.53	1.0201	1.0506	1.0000	1.0000	541.2	83.87	3.78
Other Outpatient	28.3	74.82	0.18	1.0201	1.0506	1.0000	1.0000	28.9	78.61	0.19
Subtotal Outpatient Hospital			**$ 7.75**							**$ 8.31**
Institutional										
DHHS Nursing Home	1,306.7	$ 155.14	$ 16.89	1.0201	1.0050	1.0000	1.0321	1,332.9	$ 160.92	$ 17.87
DMH Nursing Home	9.2	247.33	0.19	1.0201	1.0050	1.0000	1.0027	9.4	249.23	0.19
Nursing Home Swing Beds	-	-	-	1.0201	1.0050	1.0000	1.0000	-	-	-
Hospice Room & Board	95.9	148.69	1.19	1.0201	1.0050	1.0000	1.0323	97.8	154.25	1.26
Subtotal Institutional			**$ 18.27**							**$ 19.33**
Professional										
Inpatient and Outpatient Surgery	526.9	$ 26.35	$ 1.16	1.0201	1.0506	1.0000	1.0000	537.5	$ 27.68	$ 1.24
Anesthesia	131.7	19.54	0.21	1.0201	1.0506	1.0000	1.0000	134.3	20.53	0.23
Inpatient Visits	1,573.1	20.63	2.70	1.0201	1.0506	1.0000	1.0000	1,604.7	21.67	2.90
MH/SA	2,193.0	11.41	2.09	1.0201	1.0506	1.0000	1.0000	2,237.1	11.99	2.23
Emergency Room	202.3	32.19	0.54	1.0201	1.0506	1.0000	1.0000	206.4	33.82	0.58
Office/Home Visits/Consults	3,155.0	29.64	7.79	1.0201	1.0506	1.0000	1.0000	3,218.5	31.14	8.35
Pathology/Lab	717.7	3.63	0.22	1.0201	1.0506	1.0000	1.0000	732.1	3.82	0.23
Radiology	882.9	14.64	1.08	1.0201	1.0506	1.0000	1.0000	900.7	15.38	1.15
Office Administered Drugs	32,193.3	2.21	5.92	1.0201	1.0506	1.0000	1.0000	32,840.4	2.32	6.34
Physical Exams	28.6	17.40	0.04	1.0201	1.0506	1.0000	1.0000	29.2	18.28	0.04
Therapy	138.0	4.04	0.05	1.0201	1.0506	1.0000	1.0000	140.8	4.24	0.05
Vision	176.5	26.95	0.40	1.0201	1.0506	1.0000	1.0000	180.0	28.31	0.42
Other Professional	2,783.4	6.40	1.48	1.0201	1.0506	1.0000	1.0000	2,839.4	6.72	1.59
Subtotal Professional			**$ 23.68**							**$ 25.38**
Ancillary										
Prescription Drugs	474.0	$ 7.83	$ 0.31	1.0201	1.0100	1.0000	1.0000	483.5	$ 7.91	$ 0.32
Transportation	40.6	26.44	0.09	1.0201	1.0506	1.0000	1.0000	41.4	27.78	0.10
DME/Prosthetics	11,412.7	3.70	3.52	1.0201	1.0506	1.0000	1.0000	11,642.1	3.89	3.77
Incontinence Supplies	450.4	31.33	1.18	1.0201	1.0506	1.0000	1.0000	459.5	32.92	1.26
Other Ancillary	1,188.6	6.70	0.66	1.0201	1.0506	1.0000	1.0000	1,212.5	7.03	0.71
Subtotal Ancillary			**$ 5.76**							**$ 6.16**
Waiver Services										
Personal Care I (General Housekeeping)	41.8	$ 13.71	$ 0.05	1.0404	1.0000	1.0000	1.0853	43.5	$ 14.88	$ 0.05
Personal Care II - Homemaker	44.0	23.84	0.09	1.0404	1.0000	1.0000	1.0824	45.7	25.80	0.10
Attendant/Companion	3.1	28.32	0.01	1.0404	1.0000	1.0000	1.0544	3.3	29.86	0.01
PA, RN, LPN, CNA Providers and Therapies	-	-	-	1.0404	1.0000	1.0000	1.0000	-	-	-
Home Delivered Meals	12.1	37.05	0.04	1.0404	1.0000	1.0000	1.0000	12.6	37.05	0.04
Adult Day Health Care	4.5	52.22	0.02	1.0404	1.0000	1.0000	1.0800	4.7	56.40	0.02
Case Management	15.6	72.08	0.09	1.0404	1.0000	1.0000	1.0000	16.3	72.08	0.10
Other Waiver Services	9.0	36.06	0.03	1.0404	1.0000	1.0000	1.0000	9.3	36.06	0.03
Subtotal Waiver Services			**$ 0.32**							**$ 0.35**
Total Medical Cost			**$ 82.37**							**$ 87.00**

Appendix D: Capitation Rate Development – Nursing Facility

South Carolina Department of Health and Human Services
Calendar Year 2019 Healthy Connections Prime Capitation Rate Development
FFS Base Experience Data Adjustments - Calendar Year 2017
Paid through September 2018

Rate Cell: Nursing Facility		2017 FFS Base Experience			Data Adjustments	Program and Policy Adjustments		2017 FFS Adjusted Experience		
Experience Member Months:	**86,793**									
Category of Service		**Utilization per 1,000**	**Cost per Service**	**PMPM**	**Completion Adjustment**	**Utilization Adjustment**	**Cost Adjustment**	**Utilization per 1,000**	**Cost per Service**	**PMPM**
Inpatient Hospital										
Inpatient Medical/Surgical/Non-Delivery		1,408.7	$ 241.19	$ 28.31	1.0084	1.0000	1.0000	1,420.6	$ 241.19	$ 28.55
Inpatient MH/SA		17.8	198.54	0.30	1.0084	1.0000	1.0000	18.0	198.54	0.30
Other Inpatient		-	-	-	1.0084	1.0000	1.0000	-	-	-
Subtotal Inpatient Hospital				**$ 28.61**						**$ 28.85**
Outpatient Hospital										
Surgery		126.5	$ 126.92	$ 1.34	1.0161	1.0000	1.0000	128.5	$ 126.92	$ 1.36
Non-Surg - Emergency Room		122.6	65.04	0.66	1.0161	1.0000	1.0000	124.6	65.04	0.68
Non-Surg - Other		69.3	21.00	0.12	1.0161	1.0000	1.0000	70.4	21.00	0.12
Observation Room		41.1	26.77	0.09	1.0161	1.0000	1.0000	41.7	26.77	0.09
Treatment/Therapy/Testing		174.8	54.71	0.80	1.0161	1.0000	1.0000	177.6	54.71	0.81
Other Outpatient		12.3	114.26	0.12	1.0161	1.0000	1.0000	12.5	114.26	0.12
Subtotal Outpatient Hospital				**$ 3.13**						**$ 3.18**
Institutional										
DHHS Nursing Home		323,005.5	$ 174.07	$ 4,685.44	1.0071	1.0000	1.0210	325,297.3	$ 177.72	$ 4,817.69
DMH Nursing Home		4,568.7	336.99	128.30	1.0071	1.0000	1.0195	4,601.1	343.55	131.73
Nursing Home Swing Beds		71.3	168.65	1.00	1.0071	1.0000	1.0000	71.8	168.65	1.01
Hospice Room & Board		25,144.4	131.30	275.12	1.0071	1.0000	1.2689	25,322.8	166.61	351.58
Subtotal Institutional				**$ 5,089.87**						**$ 5,302.01**
Professional										
Inpatient and Outpatient Surgery		281.2	$ 20.15	$ 0.47	1.0069	1.0000	1.0000	283.1	$ 20.15	$ 0.48
Anesthesia		85.0	15.08	0.11	1.0069	1.0000	1.0000	85.6	15.08	0.11
Inpatient Visits		6,331.9	21.71	11.45	1.0069	1.0000	1.0000	6,375.3	21.71	11.53
MH/SA		994.6	17.29	1.43	1.0069	1.0000	1.0000	1,001.5	17.29	1.44
Emergency Room		169.6	26.30	0.37	1.0069	1.0000	1.0000	170.8	26.30	0.37
Office/Home Visits/Consults		1,082.3	37.14	3.35	1.0069	1.0000	1.0000	1,089.7	37.14	3.37
Pathology/Lab		111.7	4.86	0.05	1.0069	1.0000	1.0000	112.5	4.86	0.05
Radiology		675.8	7.63	0.43	1.0069	1.0000	1.0000	680.4	7.63	0.43
Office Administered Drugs		4,301.5	1.57	0.56	1.0069	1.0000	1.0000	4,331.0	1.57	0.57
Physical Exams		0.3	46.34	0.00	1.0069	1.0000	1.0000	0.3	46.34	0.00
Therapy		-	-	-	1.0069	1.0000	1.0000	-	-	-
Vision		54.6	31.74	0.14	1.0069	1.0000	1.0000	55.0	31.74	0.15
Other Professional		665.6	6.15	0.34	1.0069	1.0000	1.0000	670.1	6.15	0.34
Subtotal Professional				**$ 18.71**						**$ 18.84**
Ancillary										
Prescription Drugs		1,491.7	$ 6.27	$ 0.78	1.0003	1.0000	1.0000	1,492.2	$ 6.27	$ 0.78
Transportation		8.8	35.30	0.03	1.0790	1.0000	1.0000	9.5	35.30	0.03
DME/Prosthetics		62,258.8	0.26	1.33	1.0790	1.0000	1.0000	67,180.2	0.26	1.43
Incontinence Supplies		14.2	35.89	0.04	1.0790	1.0000	1.0000	15.4	35.89	0.05
Other Ancillary		43.0	14.28	0.05	1.0790	1.0000	1.0000	46.4	14.28	0.06
Subtotal Ancillary				**$ 2.22**						**$ 2.34**
Waiver Services										
Personal Care I (General Housekeeping)		1.9	$ 15.20	$ 0.00	1.0000	1.0000	1.0000	1.9	$ 15.20	$ 0.00
Personal Care II - Homemaker		1.9	20.89	0.00	1.0000	1.0000	1.0000	1.9	20.89	0.00
Attendant/Companion		-	-	-	1.0000	1.0000	1.0000	-	-	-
PA, RN, LPN, CNA Providers and Therapies		-	-	-	1.0000	1.0000	1.0000	-	-	-
Home Delivered Meals		0.1	73.22	0.00	1.0000	1.0000	1.0000	0.1	73.22	0.00
Adult Day Health Care		-	-	-	1.0000	1.0000	1.0000	-	-	-
Case Management		0.8	68.50	0.00	1.0000	1.0000	1.0507	0.8	71.98	0.00
Other Waiver Services		-	-	-	1.0000	1.0000	1.0000	-	-	-
Subtotal Waiver Services				**$ 0.01**						**$ 0.01**
Total Medical Cost				**$ 5,142.55**						**$ 5,355.23**

South Carolina Department of Health and Human Services
Calendar Year 2019 Healthy Connections Prime Capitation Rate Development
January 2019 to December 2019 Capitation Rates

Rate Cell: Nursing Facility	2017 FFS Adjusted Experience			Trend Adjustments		Program and Policy Adjustments		CY 2019 Capitation Rate		
Category of Service	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital										
Inpatient Medical/Surgical/Non-Delivery	1,420.6	$ 241.19	$ 28.55	1.0000	1.0100	1.0000	1.0301	1,420.6	$ 250.95	$ 29.71
Inpatient MH/SA	18.0	198.54	0.30	1.0000	1.0100	1.0000	1.0262	18.0	205.80	0.31
Other Inpatient	-	-	-	1.0000	1.0100	1.0000	1.0000	-	-	-
Subtotal Inpatient Hospital			**$ 28.85**							**$ 30.02**
Outpatient Hospital										
Surgery	128.5	$ 126.92	$ 1.36	1.0201	1.0506	1.0000	1.0000	131.1	$ 133.35	$ 1.46
Non-Surg - Emergency Room	124.6	65.04	0.68	1.0201	1.0506	1.0000	1.0000	127.1	68.33	0.72
Non-Surg - Other	70.4	21.00	0.12	1.0201	1.0506	1.0000	1.0000	71.8	22.06	0.13
Observation Room	41.7	26.77	0.09	1.0201	1.0506	1.0000	1.0000	42.6	28.12	0.10
Treatment/Therapy/Testing	177.6	54.71	0.81	1.0201	1.0506	1.0000	1.0000	181.1	57.48	0.87
Other Outpatient	12.5	114.26	0.12	1.0201	1.0506	1.0000	1.0000	12.8	120.04	0.13
Subtotal Outpatient Hospital			**$ 3.18**							**$ 3.41**
Institutional										
DHHS Nursing Home	325,297.3	$ 177.72	$ 4,817.69	1.0201	1.0050	1.0000	1.0335	331,835.7	$ 184.60	$ 5,104.71
DMH Nursing Home	4,601.1	343.55	131.73	1.0201	1.0050	1.0000	1.0027	4,693.6	346.19	135.40
Nursing Home Swing Beds	71.8	168.65	1.01	1.0201	1.0050	1.0000	1.0000	73.3	169.49	1.04
Hospice Room & Board	25,322.8	166.61	351.58	1.0201	1.0050	1.0000	1.0335	25,831.8	173.05	372.53
Subtotal Institutional			**$ 5,302.01**							**$ 5,613.67**
Professional										
Inpatient and Outpatient Surgery	283.1	$ 20.15	$ 0.48	1.0201	1.0506	1.0000	1.0000	288.8	$ 21.17	$ 0.51
Anesthesia	85.6	15.08	0.11	1.0201	1.0506	1.0000	1.0000	87.3	15.84	0.12
Inpatient Visits	6,375.3	21.71	11.53	1.0201	1.0506	1.0000	1.0000	6,503.4	22.81	12.36
MH/SA	1,001.5	17.29	1.44	1.0201	1.0506	1.0000	1.0000	1,021.6	18.17	1.55
Emergency Room	170.8	26.30	0.37	1.0201	1.0506	1.0000	1.0000	174.2	27.63	0.40
Office/Home Visits/Consults	1,089.7	37.14	3.37	1.0201	1.0506	1.0000	1.0000	1,111.6	39.02	3.61
Pathology/Lab	112.5	4.86	0.05	1.0201	1.0506	1.0000	1.0000	114.7	5.11	0.05
Radiology	680.4	7.63	0.43	1.0201	1.0506	1.0000	1.0000	694.1	8.01	0.46
Office Administered Drugs	4,331.0	1.57	0.57	1.0201	1.0506	1.0000	1.0000	4,418.1	1.65	0.61
Physical Exams	0.3	46.34	0.00	1.0201	1.0506	1.0000	1.0000	0.3	48.69	0.00
Therapy	-	-	-	1.0201	1.0506	1.0000	1.0000	-	-	-
Vision	55.0	31.74	0.15	1.0201	1.0506	1.0000	1.0000	56.1	33.35	0.16
Other Professional	670.1	6.15	0.34	1.0201	1.0506	1.0000	1.0000	683.6	6.46	0.37
Subtotal Professional			**$ 18.84**							**$ 20.19**
Ancillary										
Prescription Drugs	1,492.2	$ 6.27	$ 0.78	1.0201	1.0100	1.0000	1.0000	1,522.2	$ 6.33	$ 0.80
Transportation	9.5	35.30	0.03	1.0201	1.0506	1.0000	1.0000	9.7	37.09	0.03
DME/Prosthetics	67,180.2	0.26	1.43	1.0201	1.0506	1.0000	1.0000	68,530.5	0.27	1.53
Incontinence Supplies	15.4	35.89	0.05	1.0201	1.0506	1.0000	1.0000	15.7	37.70	0.05
Other Ancillary	46.4	14.28	0.06	1.0201	1.0506	1.0000	1.0000	47.3	15.00	0.06
Subtotal Ancillary			**$ 2.34**							**$ 2.47**
Waiver Services										
Personal Care I (General Housekeeping)	1.9	$ 15.20	$ 0.00	1.0404	1.0000	1.0000	1.0853	2.0	$ 16.50	$ 0.00
Personal Care II - Homemaker	1.9	20.89	0.00	1.0404	1.0000	1.0000	1.0824	2.0	22.61	0.00
Attendant/Companion	-	-	-	1.0404	1.0000	1.0000	1.0544	-	-	-
PA, RN, LPN, CNA Providers and Therapies	-	-	-	1.0404	1.0000	1.0000	1.0000	-	-	-
Home Delivered Meals	0.1	73.22	0.00	1.0404	1.0000	1.0000	1.0000	0.1	73.22	0.00
Adult Day Health Care	-	-	-	1.0404	1.0000	1.0000	1.0800	-	-	-
Case Management	0.8	71.98	0.00	1.0404	1.0000	1.0000	1.0000	0.9	71.98	0.01
Other Waiver Services	-	-	-	1.0404	1.0000	1.0000	1.0000	-	-	-
Subtotal Waiver Services			**$ 0.01**							**$ 0.01**
Total Medical Cost			**$ 5,355.23**							**$ 5,669.77**

Appendix E: Capitation Rate Development – HCBS Waiver

South Carolina Department of Health and Human Services
Calendar Year 2019 Healthy Connections Prime Capitation Rate Development
FFS Base Experience Data Adjustments - Calendar Year 2017
Paid through September 2018

Rate Cell: HCBS		2017 FFS Base Experience			Data Adjustments	Program and Policy Adjustments		2017 FFS Adjusted Experience		
Experience Member Months:	33,765									
Category of Service		**Utilization per 1,000**	**Cost per Service**	**PMPM**	**Completion Adjustment**	**Utilization Adjustment**	**Cost Adjustment**	**Utilization per 1,000**	**Cost per Service**	**PMPM**
Inpatient Hospital										
Inpatient Medical/Surgical/Non-Delivery		2,432.3	$ 251.15	$ 50.91	1.0088	1.0000	1.0000	2,453.8	$ 251.15	$ 51.36
Inpatient MH/SA		40.2	118.63	0.40	1.0088	1.0000	1.0000	40.5	118.63	0.40
Other Inpatient		-	-	-	1.0088	1.0000	1.0000	-	-	-
Subtotal Inpatient Hospital				**$ 51.30**						**$ 51.76**
Outpatient Hospital										
Surgery		264.4	$ 165.81	$ 3.65	1.0301	1.0000	1.0000	272.4	$ 165.81	$ 3.76
Non-Surg - Emergency Room		454.6	64.53	2.44	1.0301	1.0000	1.0000	468.2	64.53	2.52
Non-Surg - Other		278.6	18.60	0.43	1.0301	1.0000	1.0000	287.0	18.60	0.44
Observation Room		42.6	41.80	0.15	1.0301	1.0000	1.0000	43.9	41.80	0.15
Treatment/Therapy/Testing		557.3	76.52	3.55	1.0301	1.0000	1.0000	574.0	76.52	3.66
Other Outpatient		32.3	73.51	0.20	1.0301	1.0000	1.0000	33.3	73.51	0.20
Subtotal Outpatient Hospital				**$ 10.43**						**$ 10.74**
Institutional										
DHHS Nursing Home		1,197.3	$ 153.73	$ 15.34	1.0219	1.0000	1.0338	1,223.6	$ 158.93	$ 16.21
DMH Nursing Home		-	-	-	1.0219	1.0000	1.0195	-	-	-
Nursing Home Swing Beds		5.0	164.50	0.07	1.0219	1.0000	1.0000	5.1	164.50	0.07
Hospice Room & Board		83.2	155.58	1.08	1.0219	1.0000	1.0280	85.0	159.94	1.13
Subtotal Institutional				**$ 16.49**						**$ 17.41**
Professional										
Inpatient and Outpatient Surgery		692.7	$ 29.01	$ 1.67	1.0062	1.0000	1.0000	696.9	$ 29.01	$ 1.69
Anesthesia		177.7	15.10	0.22	1.0062	1.0000	1.0000	178.8	15.10	0.22
Inpatient Visits		3,412.2	20.49	5.83	1.0062	1.0000	1.0000	3,433.2	20.49	5.86
MH/SA		1,800.8	11.08	1.66	1.0062	1.0000	1.0000	1,811.9	11.08	1.67
Emergency Room		417.2	28.01	0.97	1.0062	1.0000	1.0000	419.8	28.01	0.98
Office/Home Visits/Consults		3,811.6	26.09	8.29	1.0062	1.0000	1.0000	3,835.1	26.09	8.34
Pathology/Lab		854.7	2.68	0.19	1.0062	1.0000	1.0000	860.0	2.68	0.19
Radiology		1,137.6	9.74	0.92	1.0062	1.0000	1.0000	1,144.6	9.74	0.93
Office Administered Drugs		37,722.3	2.11	6.62	1.0062	1.0000	1.0000	37,954.8	2.11	6.66
Physical Exams		34.5	16.71	0.05	1.0062	1.0000	1.0000	34.7	16.71	0.05
Therapy		294.3	2.33	0.06	1.0062	1.0000	1.0000	296.1	2.33	0.06
Vision		149.6	23.58	0.29	1.0062	1.0000	1.0000	150.5	23.58	0.30
Other Professional		2,193.9	6.98	1.28	1.0062	1.0000	1.0000	2,207.4	6.98	1.28
Subtotal Professional				**$ 28.06**						**$ 28.23**
Ancillary										
Prescription Drugs		757.7	$ 29.05	$ 1.83	1.0000	1.0000	1.0000	757.7	$ 29.05	$ 1.83
Transportation		130.1	31.89	0.35	1.0191	1.0000	1.0000	132.6	31.89	0.35
DME/Prosthetics		69,403.1	2.52	14.60	1.0191	1.0000	1.0000	70,728.4	2.52	14.88
Incontinence Supplies		15,403.3	28.35	36.38	1.0191	1.0000	1.0000	15,697.4	28.35	37.08
Other Ancillary		403.4	53.79	1.81	1.0191	1.0000	1.0000	411.1	53.79	1.84
Subtotal Ancillary				**$ 54.98**						**$ 55.99**
Waiver Services										
Personal Care I (General Housekeeping)		147,638.6	$ 15.30	$ 188.18	1.0000	1.0000	1.0000	147,645.3	$ 15.30	$ 188.19
Personal Care II - Homemaker		167,464.4	26.11	364.32	1.0000	1.0000	1.0000	167,472.0	26.11	364.34
Attendant/Companion		50,349.9	25.89	108.64	1.0000	1.0000	1.0000	50,352.2	25.89	108.64
PA, RN, LPN, CNA Providers and Therapies		8.2	182.54	0.12	1.0000	1.0000	1.0000	8.2	182.54	0.12
Home Delivered Meals		27,255.1	38.30	86.99	1.0000	1.0000	1.0000	27,256.3	38.30	86.99
Adult Day Health Care		17,699.9	52.22	77.02	1.0000	1.0000	1.0000	17,700.7	52.22	77.03
Case Management		11,711.4	68.52	66.88	1.0000	1.0000	1.0507	11,711.9	72.00	70.27
Other Waiver Services		21,715.9	34.80	62.98	1.0000	1.0000	1.0000	21,716.8	34.80	62.98
Subtotal Waiver Services				**$ 955.12**						**$ 958.56**
Total Medical Cost				**$ 1,116.38**						**$ 1,122.69**

South Carolina Department of Health and Human Services
Calendar Year 2019 Healthy Connections Prime Capitation Rate Development
January 2019 to December 2019 Capitation Rates

Rate Cell: HCBS	2017 FFS Adjusted Experience			Trend Adjustments		Program and Policy Adjustments		CY 2019 Capitation Rate		
Category of Service	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital										
Inpatient Medical/Surgical/Non-Delivery	2,453.8	$ 251.15	$ 51.36	1.0000	1.0100	1.0000	1.0263	2,453.8	$ 260.34	$ 53.24
Inpatient MH/SA	40.5	118.63	0.40	1.0000	1.0100	1.0000	1.0162	40.5	121.76	0.41
Other Inpatient	-	-	-	1.0000	1.0100	1.0000	1.0000	-	-	-
Subtotal Inpatient Hospital			**$ 51.76**							**$ 53.65**
Outpatient Hospital										
Surgery	272.4	$ 165.81	$ 3.76	1.0201	1.0506	1.0000	1.0000	277.9	$ 174.20	$ 4.03
Non-Surg - Emergency Room	468.2	64.53	2.52	1.0201	1.0506	1.0000	1.0000	477.7	67.80	2.70
Non-Surg - Other	287.0	18.60	0.44	1.0201	1.0506	1.0000	1.0000	292.8	19.54	0.48
Observation Room	43.9	41.80	0.15	1.0201	1.0506	1.0000	1.0000	44.8	43.91	0.16
Treatment/Therapy/Testing	574.0	76.52	3.66	1.0201	1.0506	1.0000	1.0000	585.6	80.40	3.92
Other Outpatient	33.3	73.51	0.20	1.0201	1.0506	1.0000	1.0000	34.0	77.24	0.22
Subtotal Outpatient Hospital			**$ 10.74**							**$ 11.51**
Institutional										
DHHS Nursing Home	1,223.6	$ 158.93	$ 16.21	1.0201	1.0050	1.0000	1.0321	1,248.2	$ 164.85	$ 17.15
DMH Nursing Home	-	-	-	1.0201	1.0050	1.0000	1.0027	-	-	-
Nursing Home Swing Beds	5.1	164.50	0.07	1.0201	1.0050	1.0000	1.0000	5.2	165.32	0.07
Hospice Room & Board	85.0	159.94	1.13	1.0201	1.0050	1.0000	1.0323	86.7	165.93	1.20
Subtotal Institutional			**$ 17.41**							**$ 18.42**
Professional										
Inpatient and Outpatient Surgery	696.9	$ 29.01	$ 1.69	1.0201	1.0506	1.0000	1.0000	710.9	$ 30.48	$ 1.81
Anesthesia	178.8	15.10	0.22	1.0201	1.0506	1.0000	1.0000	182.4	15.87	0.24
Inpatient Visits	3,433.2	20.49	5.86	1.0201	1.0506	1.0000	1.0000	3,502.2	21.53	6.28
MH/SA	1,811.9	11.08	1.67	1.0201	1.0506	1.0000	1.0000	1,848.3	11.64	1.79
Emergency Room	419.8	28.01	0.98	1.0201	1.0506	1.0000	1.0000	428.2	29.43	1.05
Office/Home Visits/Consults	3,835.1	26.09	8.34	1.0201	1.0506	1.0000	1.0000	3,912.2	27.41	8.94
Pathology/Lab	860.0	2.68	0.19	1.0201	1.0506	1.0000	1.0000	877.3	2.81	0.21
Radiology	1,144.6	9.74	0.93	1.0201	1.0506	1.0000	1.0000	1,167.6	10.24	1.00
Office Administered Drugs	37,954.8	2.11	6.66	1.0201	1.0506	1.0000	1.0000	38,717.6	2.21	7.14
Physical Exams	34.7	16.71	0.05	1.0201	1.0506	1.0000	1.0000	35.4	17.56	0.05
Therapy	296.1	2.33	0.06	1.0201	1.0506	1.0000	1.0000	302.0	2.45	0.06
Vision	150.5	23.58	0.30	1.0201	1.0506	1.0000	1.0000	153.6	24.77	0.32
Other Professional	2,207.4	6.98	1.28	1.0201	1.0506	1.0000	1.0000	2,251.8	7.34	1.38
Subtotal Professional			**$ 28.23**							**$ 30.26**
Ancillary										
Prescription Drugs	757.7	$ 29.05	$ 1.83	1.0201	1.0100	1.0000	1.0000	772.9	$ 29.34	$ 1.89
Transportation	132.6	31.89	0.35	1.0201	1.0506	1.0000	1.0000	135.2	33.50	0.38
DME/Prosthetics	70,728.4	2.52	14.88	1.0201	1.0506	1.0000	1.0000	72,150.1	2.65	15.95
Incontinence Supplies	15,697.4	28.35	37.08	1.0201	1.0506	1.0000	1.0000	16,012.9	29.78	39.74
Other Ancillary	411.1	53.79	1.84	1.0201	1.0506	1.0000	1.0000	419.3	56.52	1.97
Subtotal Ancillary			**$ 55.99**							**$ 59.93**
Waiver Services										
Personal Care I (General Housekeeping)	147,645.3	$ 15.30	$ 188.19	1.0404	1.0000	1.0000	1.0853	153,610.1	$ 16.60	$ 212.49
Personal Care II - Homemaker	167,472.0	26.11	364.34	1.0404	1.0000	1.0000	1.0824	174,237.9	28.26	410.27
Attendant/Companion	50,352.2	25.89	108.64	1.0404	1.0000	1.0000	1.0544	52,386.4	27.30	119.18
PA, RN, LPN, CNA Providers and Therapies	8.2	182.54	0.12	1.0404	1.0000	1.0000	1.0000	8.5	182.54	0.13
Home Delivered Meals	27,256.3	38.30	86.99	1.0404	1.0000	1.0000	1.0000	28,357.5	38.30	90.50
Adult Day Health Care	17,700.7	52.22	77.03	1.0404	1.0000	1.0000	1.0800	18,415.8	56.40	86.55
Case Management	11,711.9	72.00	70.27	1.0404	1.0000	1.0000	1.0000	12,185.1	72.00	73.11
Other Waiver Services	21,716.8	34.80	62.98	1.0404	1.0000	1.0000	1.0000	22,594.2	34.80	65.52
Subtotal Waiver Services			**$ 958.56**							**$ 1,057.76**
Total Medical Cost			**$ 1,122.69**							**$ 1,231.53**

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